U.S. Department of Health and Human Services
Health Care Financing Administration

Financial Report

Fiscal Year 1999

U.S. Department of Health and Human Services
Donna Shalala, Secretary

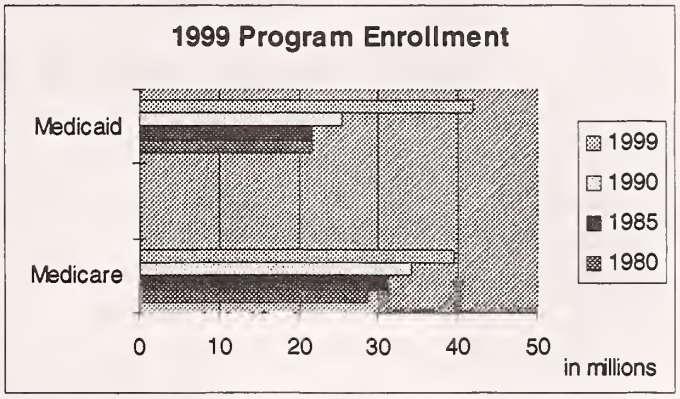
Health Care Financing Administration
Nancy-Ann Min DeParle, Administrator

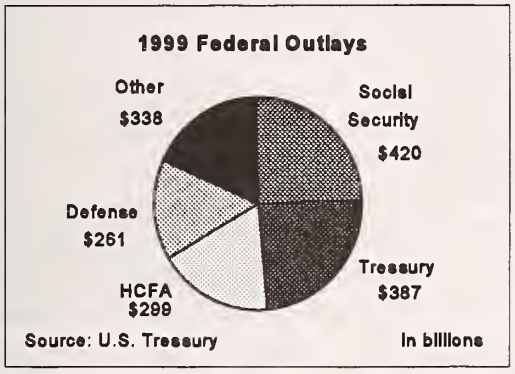
THE Chief Financial Officers (CFO) Act of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, the Act instituted a new Federal financial management structure and process modeled on private sector practices. It also established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report. The form and content of this Financial Report follows guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects the Health Care Financing Administration's (HCFA) support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

U.S. Department of Health and Human Services
Health Care Financing Administartion
7500 Security Boulevard
Baltimore, Maryland 21244-1850

The Health Care Financing Administration AT A GLANCE

➤ HCFA is the largest purchaser of health care in the world. The Medicare and Medicaid programs that we administer provide health care for one in four Americans. Medicare enrollment has increased from 19.5 million beneficiaries in 1967 to 39.5 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to 41.9 million beneficiaries.





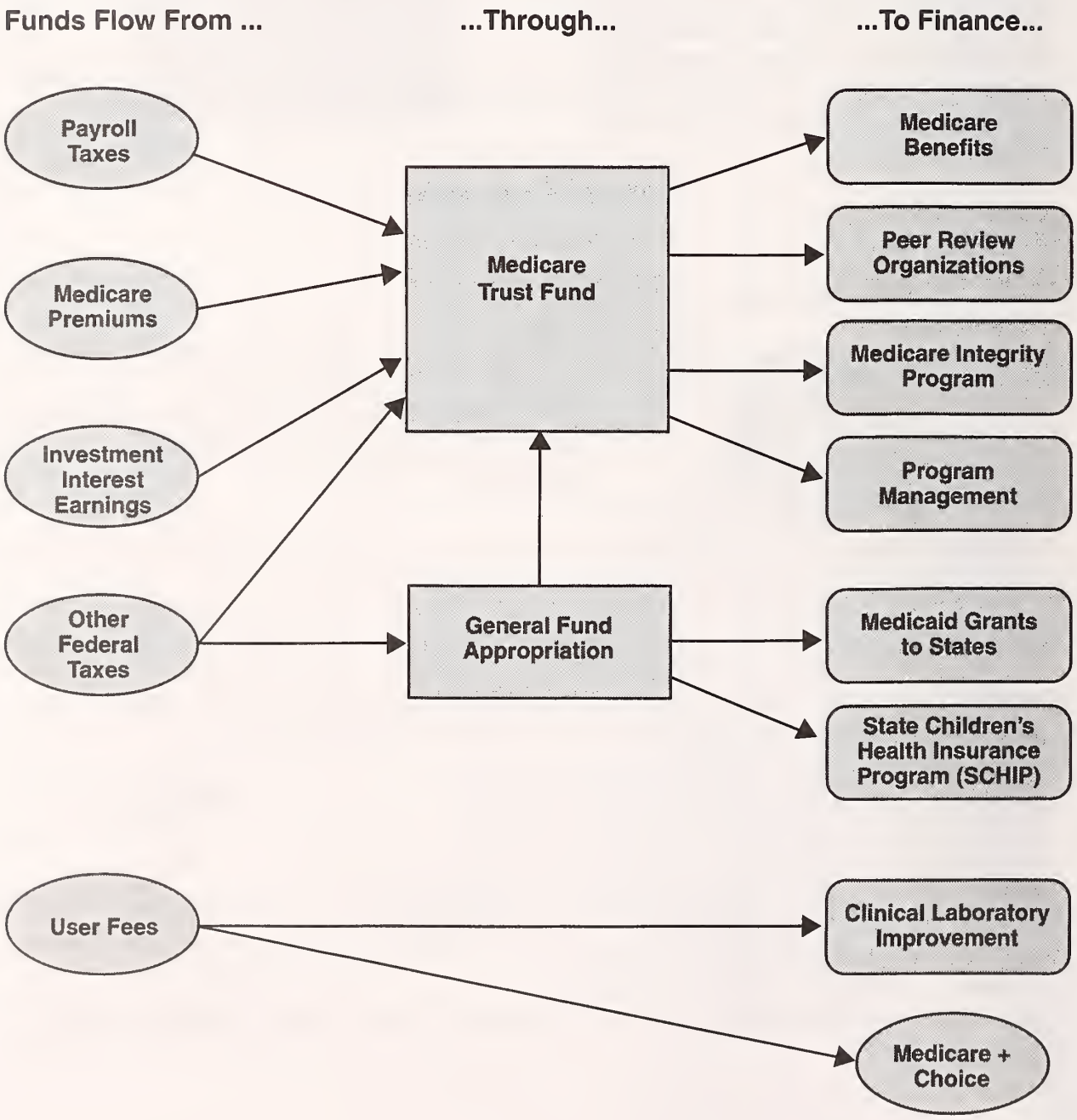
➤ HCFA outlayed $299 billion (net of offsetting receipts) in fiscal year (FY) 1999, 17.5 percent of total Federal outlays. The only agencies that outlayed more are the Social Security Administration and the Department of Treasury.

➤ HCFA has 4,200 Federal employees, but does most of its work through third parties. HCFA and its contractors pay more than 870 million Medicare claims annually, monitor quality of care, provide States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. HCFA also assures the safety and quality of medical facilities, provides health insurance protections to workers changing jobs, and maintains the largest collection of health care data in the United States.

HCFA and Its Partners

Type	Employees
HCFA	4,200
Medicare Contractors	21,500
State Surveyors	5,900
Peer Review	1,800

FINANCING OF HCFA PROGRAMS & OPERATIONS



A Message from the Administrator

I am pleased to provide the Health Care Financing Administration's (HCFA's) annual financial report for fiscal year (FY) 1999. HCFA is the nation's largest health insurer, providing coverage to about 75 million people. Our programs--Medicare, Medicaid, and the new State Children's Health Insurance Program--now provide more coverage, more health plan options, and more health care security to Americans than ever before. HCFA outlays were $299 billion in FY 1999, and represents the Federal Government's third largest outlay. Medicare alone now processes almost 870 million claims a year, is the nation's largest purchaser of managed care, and accounts for 11 percent of the Federal budget.

Much time and effort was spent this year meeting the Year 2000, or Y2K, computer programming challenge. All of our 25 internal mission critical systems and our 78 external mission critical systems that our claims processing contractors use to pay Medicare claims were renovated, fully tested, and certified compliant by independent experts prior to January 1, 2000. I am pleased to report that we transitioned into year 2000 without major incident.

We are continuing to implement our comprehensive Program Integrity Plan to improve the overall fiscal integrity of our programs. Medicare contractors who pay claims are required to use special computer systems to help identify and investigate suspicious billing patterns. We have hired Medicare Integrity Program specialty contractors, who have broad experience and expertise in conducting audits, performing medical reviews, and educating providers. We expect that our continued focus on paying claims correctly the first time will further reduce the estimated claims error rate. For FY 1999, the error rate is 7.97 percent compared to 7.1 percent for 1998, and 11 percent in FY 1997. We are satisfied to have maintained the gains of the last two years, but are concerned that we did not lower the error rate even further. We have achieved improvements as a result of our corrective actions, but realize that additional efforts are necessary to reduce the errors and meet our goal of a 5 percent claims error rate by 2002.

During FY 1999 we also fully implemented the majority of the 300 + provisions included in the Balanced Budget Act of 1997 (BBA). These provisions include the Medicare+Choice program, important new preventive benefits, prospective payment system for skilled nursing facilities, and other payment system reforms that promote access, efficiency, and prudent use of taxpayer dollars. It is clear that the BBA has contributed to promoting efficiency and slowing the growth of Medicare expenditures. However, we are proactively monitoring the impacts of the BBA to ensure that beneficiary access to quality care is not compromised.

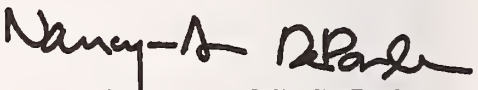
I am also pleased to report that this year we launched successfully the largest peacetime education campaign ever conducted by the Federal Government. The National Medicare Education Program was designed to help beneficiaries understand their Medicare benefits and health care options, including managed care plans, so they can make informed choices. This effort included multiple beneficiary outreach efforts such as an alliance with the public library

community to make Medicare a focus for their information and assistance efforts and partnerships with employer trade groups to help educate their retirees. We also created a national focus on caregivers and their families high-lighting the direct aid caregivers provide our beneficiaries as well as furthering our ability to educate people prior to their achieving initial eligibility to the Medicare program. This effort also included a toll free telephone line 1-800-MEDICARE (1-800-633-4227) to answer any questions, a beneficiary-oriented Internet Web site (www.medicare.gov), and the "Medicare and You 2000" handbook that was distributed nationwide to 33 million beneficiaries, 1 per household.

HCFA has faced one of the most challenging years in its history. We have risen to meet the challenges through a myriad of initiatives and extraordinary efforts that earned us recognition in 1999 by the Ford Foundation and the Council on Excellence in Government as a finalist in its "Innovations in Government" program.

As an Agency with one of the largest budgets in the Federal Government, HCFA takes its financial management responsibilities very seriously. HCFA's financial statements were first subjected to a full scope audit in FY 1996 and were disclaimed by the auditors. Since 1996 we have made significant progress towards our goal of obtaining a clean audit opinion from our auditors. Our efforts this year focused on improving internal controls at the Medicare contractors and improving our ability to properly report the value of Medicare accounts receivable. Although we recognize that much more work is needed to accomplish our ultimate goal of implementing a state-of-the-art accounting system that will include our Medicare contractors, I am proud to announce that our auditors have confirmed the progress that we have made by providing us with our first clean audit opinion on our FY 1999 Financial Statements.

As we face the next century and the work that lies ahead, I am proud of what HCFA has accomplished. We have successfully worked with Congress, the States, our beneficiaries, and the health care community to ensure that our programs are strong and well managed. We continue to successfully tackle numerous initiatives while continuing to fulfill the core missions of serving our multiple customers, ensuring our beneficiaries receive quality care, paying claims to our providers, and working with our State partners in the administration of Medicaid and the State Children's Health Insurance Program. I am confident we will continue meeting these challenges well into the 21st Century.

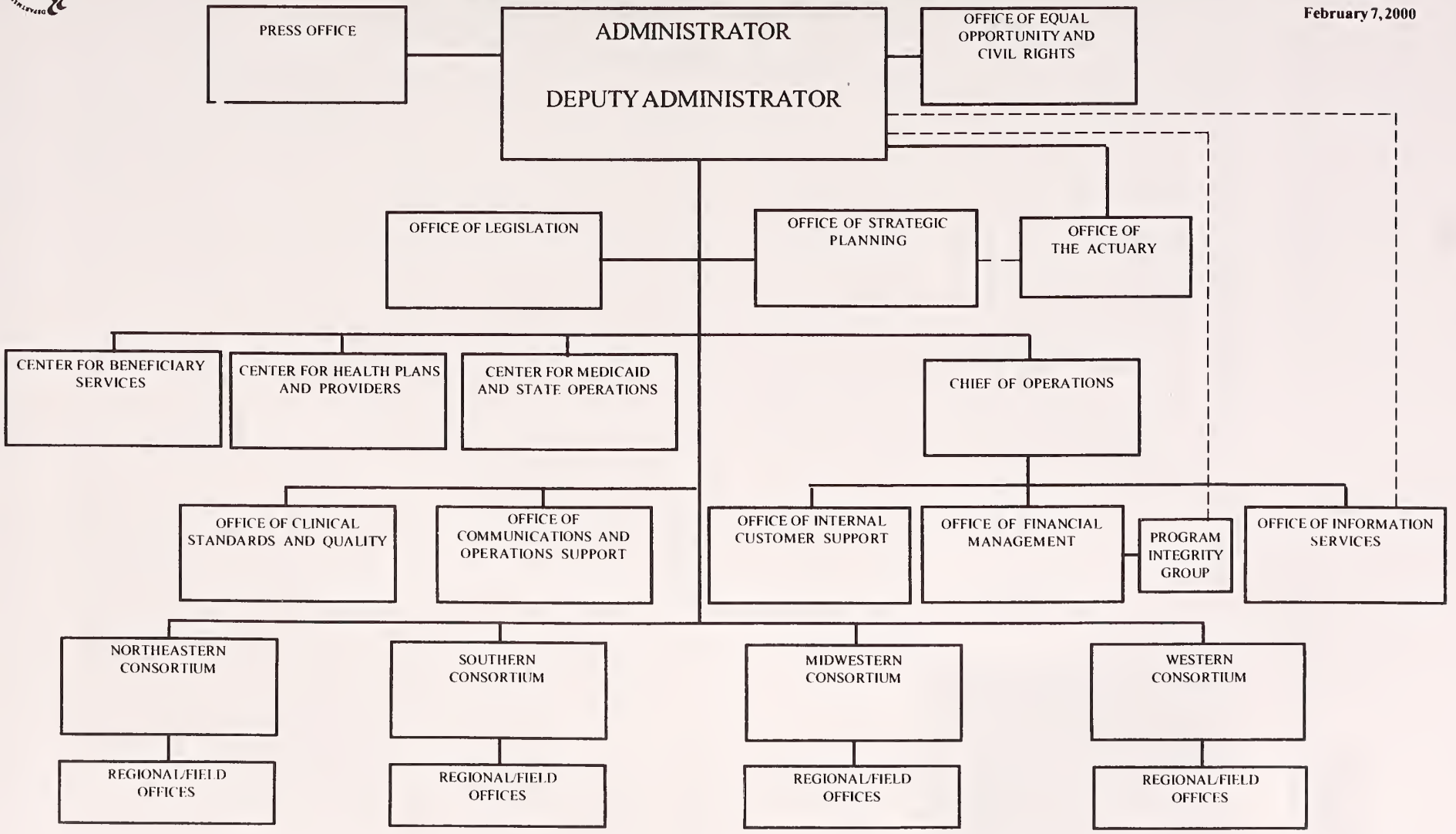


Nancy-Ann Min DeParle
February 2000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED STRUCTURE

As of February 7, 2000



A Message from the Chief Financial Officer

As HCFA's Chief Financial Officer (CFO), I am pleased to report that in FY 1999, we continued to make significant progress in improving financial management at HCFA, most notably, obtaining the first clean audit opinion on our financial statements. Prudent financial management is critical in this era of severely limited Federal resources. As an agency with one of the largest budgets in the Federal government, we in HCFA have a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible.

During FY 1999, HCFA's number one priority was to ensure that on and after January 1, 2000, Medicare and Medicaid beneficiaries experienced no interruptions in service, and that providers continued to receive prompt and accurate payment for their services. I am pleased to report that our internal mission critical systems and all Medicare contractors' mission critical systems were successfully tested, validated, and certified compliant prior to January 1, and we experienced no disruption in service or operations because of Y2K.

Since FY 1996, we have made significant improvements towards achieving a clean opinion on the HCFA financial statements and improving our financial management processes. By FY 1998, the remaining issue preventing a clean opinion was the accuracy and supportability of our accounts receivable balances, most of which are maintained on our behalf by our fiscal intermediaries and carriers. These organizations, commonly referred to as Medicare contractors, have contracted with HCFA to administer the day-to-day operations of the Medicare program. They pay claims, audit provider cost reports, establish and collect overpayments. Because the systems used by the Medicare contractors have not always produced data which was adequately supported, our auditors have had difficulty in the past validating their accounts receivable balances.

During FY 1999, we performed extensive analysis of our accounts receivables. As a result, we implemented a number of changes in the reporting of delinquent debts in order to reflect accounts receivables at their true economic value. We developed a new financial reporting policy that established standards to manage and account for delinquent non Medicare Secondary Payer (MSP) debt older than two years and MSP debt older than 180 days old. This debt will continue to be referred for collection and litigation, but will not be reported on our financial statements, because our analysis showed that there is a minimal likelihood of collecting these categories of delinquent debt. We also held training conferences to orient the contractors on the audit process and to emphasize the requirements to provide adequate documentation of accounts receivable activities. We revised HCFA instructions for the Medicare contractor financial reports submitted to HCFA and provided training to all Medicare contractors that included participation of staff from the Office of Inspector General, and the Certified Public Accountant firms engaged in the CFO audit.

Although we received a clean opinion on our financial statements, our auditors continue to have internal control concerns with many aspects of contractors' accounts receivable resulting from the

lack of a fully integrated contractor-based general ledger accounting system. We share this concern. HCFA's long-range plan is to develop and implement by FY 2004 an integrated general ledger accounting system for all Medicare contractors. A project team was convened and chartered to begin the process of developing detailed business requirements. In addition, the development of the Medicare Accounts Receivable System and the MSP Recovery Management and Accounting System will improve oversight and financial reporting over Medicare receivables. Until a fully integrated contractor-based accounting system is implemented, we anticipate extra efforts will be necessary to support accounts receivable. During FY 2000, financial management internal controls will be tested at 25 Medicare contractors. Any deficiency noted will be corrected.

We continue to make important accomplishments in other financial areas as well. In FY 1999, HCFA worked to improve the effectiveness and quality of Medicare contractor oversight through the use of Contractor Performance Evaluation (CPE) reviews. CPE reviews were redesigned to include the development of clear and measurable performance standards by moving towards a national review process with greater consistency. In FY 1999, review teams consisting of HCFA Central and Regional Office staff conducted on site reviews of critical business functions at high-risk contractors in the areas of financial reporting, medical review, benefits integrity, and millennium compliance. In addition, we continue to pay all of our administrative payments on time in compliance with the Prompt Payment Act. Over 98 percent of our payments are paid electronically. We also continued implementation of the HCFA Travel System during FY 1999. All regional offices have been trained on the travel system and are operational.

In FY 1999, we released our first Comprehensive Plan for Program Integrity to highlight HCFA's goals and overall strategy for reducing payment errors in the Medicare and Medicaid programs. We have made great strides in meeting the goals we outlined in that plan. Those initiatives focus on program management improvements and on service specific areas where we need to strengthen oversight and develop new program integrity strategies. We defined ten initiatives and are focusing our program integrity efforts accordingly. In addition, we established a Government Performance and Results Act (GPRA) goal related to the Comprehensive Plan. Based on the OIG report entitled "Improper FY 1999 Medicare Fee-For-Service Payments," the Medicare's fee-for-service payment error rate for FY 1999 was 7.97 percent, or $13.5 billion. This error rate is $9.7 billion less than in FY 1996, when the OIG developed the first national error rate. We will continue to focus our additional efforts and corrective actions to achieve our GPRA goal to reduce the error rate for all Medicare fee-for-service payments to 5 percent by FY 2002.

While the achievement of an unqualified opinion is a key accomplishment and positions HCFA for even greater accomplishments in the future, we know we have much more to do in improving HCFA's financial management.

HCFA takes its financial management responsibilities very seriously. We are committed to reducing payment errors, identifying and eliminating health care fraud, improving program oversight, and implementing a state-of-the-art Medicare contractor accounting system. These are challenging tasks, but ones, nonetheless, that we will accomplish.

A. Michelle Snyder

A. Michelle Snyder
February 2000

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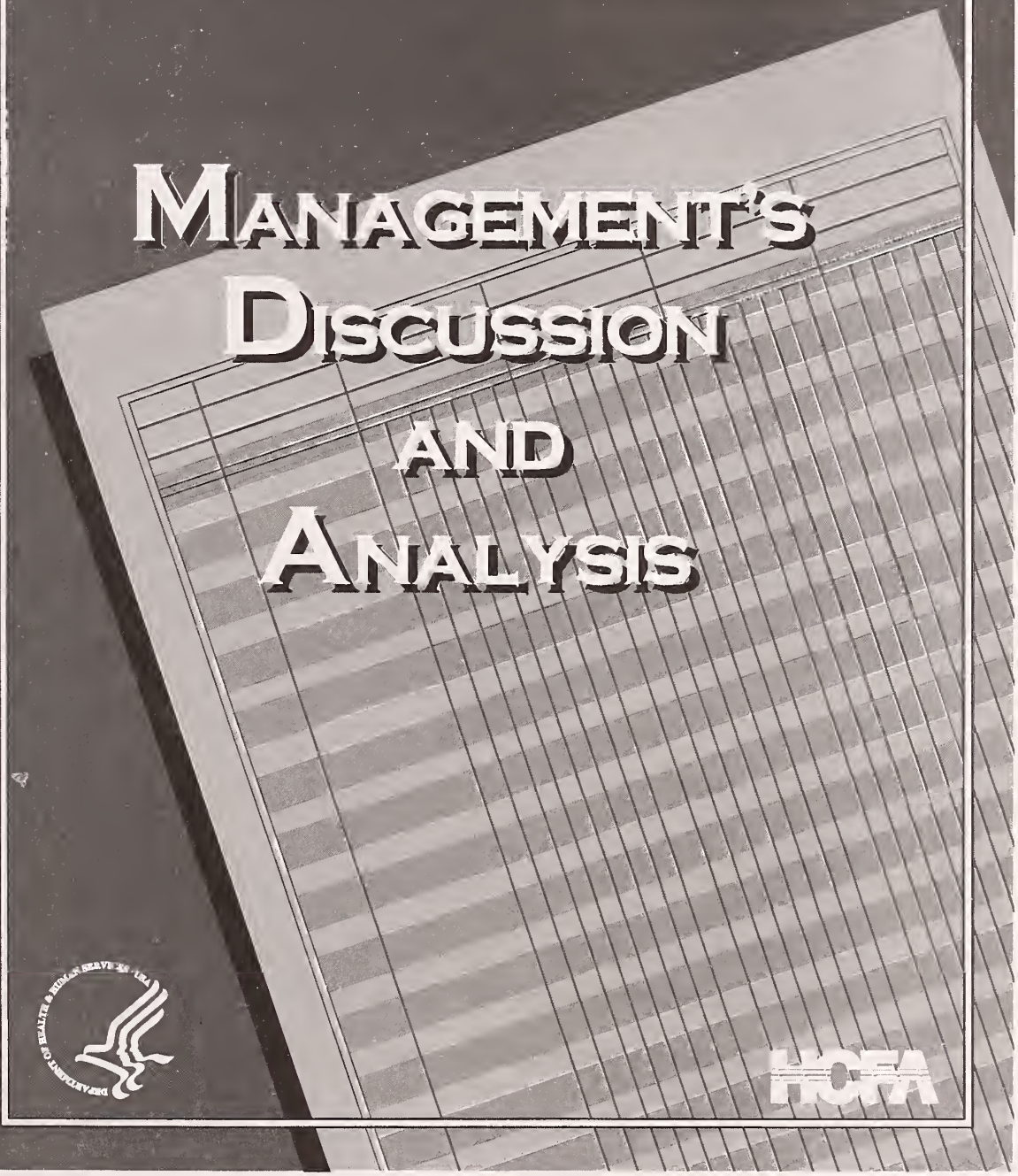
Health Care Financing Administration

Management's Discussion and Analysis



HCFA

OUR MISSION, VISION, AND GOALS

MISSION **We assure health care security for beneficiaries.** Health care security means access to affordable and quality health care services, protection of the rights and dignity of beneficiaries, and provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

VISSION **We guaratee equal access to the best health care.** This vision reflects our commitment that all individuals will be given an unconditional assurance of having the same opportunity to have their health care needs met, regardless of location, income, or other circumstances, and the quality of health care they receive is the best that can be provided.

GOALS

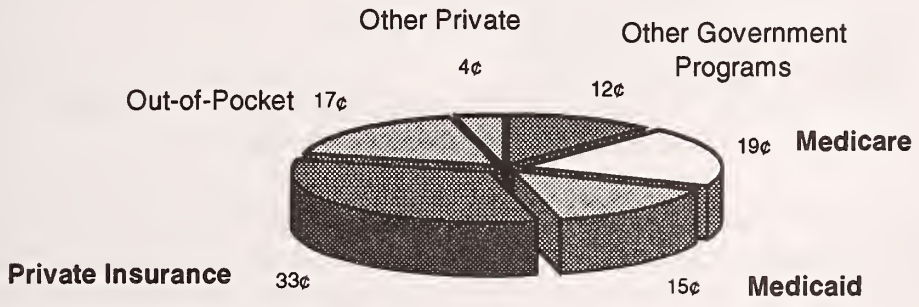
- Protect and improve beneficiary health and satisfaction
- Promote fiscal integrity of HCFA's programs
- Purchase the best value health carefor beneficiaries
- Promote beneficiary and public understanding of HCFA and its programs
- Foster excellence in the design and administration of HCFA's programs
- Provide leadership in the broader public interest to improve health

Program Profile

The Health Care Financing Administration (HCFA), an operating division of the Department of Health and Human Services (HHS), is responsible for administering Medicare, Medicaid, the State Children's Health Insurance Program, and the Clinical Laboratory Improvement Act. In conjunction with the Departments of Labor and Treasury, HCFA is also responsible for oversight of the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HCFA is the largest purchaser of health care in the world. Medicare and Medicaid outlays, including State funding, represent 33.7 cents of every dollar spent on health care in the United States -- 58.2 cents of every dollar spent on nursing homes, 48.3 cents of every dollar received by U.S. hospitals, and 28.0 cents of every dollar spent on physician services.

The Nation's Health Care Dollar 1998



Source:HCFA/OACT

HCFA outlayed $299 billion in fiscal year (FY) 1999, 17.5 percent of total Federal outlays. HCFA establishes rules for program eligibility and benefit coverages; processes and pays more than 870 million Medicare benefits claims annually; provides States with matching funds for Medicaid benefits; provides funds to States for the State Children's Health Insurance Program; assures quality of health care for beneficiaries; safeguards funds from fraud, abuse, and waste; and carries out many other important activities.

Of HCFA's 4,200 Federal employees, about 1,500 work in 10 regional offices around the country providing direct services to Medicare contractors, State agencies, health care providers, beneficiaries, and the general public. Approximately 2,700 of HCFA's employees work in Baltimore, MD and Washington, D.C., providing funds to Medicare contractors; writing policies and regulations; developing more efficient operating systems; setting payment rates; managing programs to fight fraud, waste, and abuse; monitoring contractor performance; educating and protecting beneficiaries and implementing customer service improvements; surveying hospitals, nursing homes, labs, home health agencies and other health care facilities; working with State insurance companies; and assisting States and Territories with Medicaid and the State Children's Health Insurance Program. In addition, HCFA is responsible for:

Two key financial terms are critical to understand the HCFA financial story. **Expenses** are one of the ingredients of the financial statements that begin on page 59. Expenses are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivable and accounts payable on determining annual income. Wherever possible, expenses are the basis for discussions of HCFA's financial activity. **Outlays** refer to the issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. Outlays are used in the discussions of HCFA's financial activity only when comparable expense data are not available.

- safeguarding the fiscal integrity of the Medicare and Medicaid programs to ensure that benefit payments for appropriate, medically necessary services are paid correctly the first time; recovering improper payments; and assisting law enforcement agencies in the prosecution of fraudulent activities.

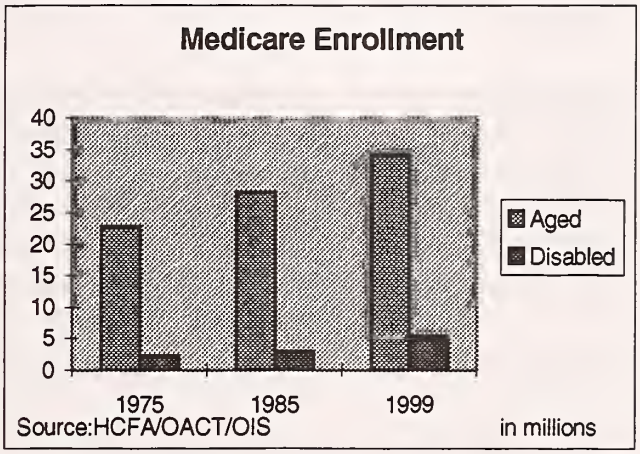
- maintaining the Nation's largest collection of health care data and providing data and analytical services to the Congress, the Executive Branch, universities, and other private sector researchers.

In 1999, HCFA's expenses total $316 billion. Funds used to administer the programs are $2.9 billion, which is less than one percent of the total expenses. In addition to HCFA's approximately 4,200 Federal employees, many important operational activities are handled through third parties: (1) 21,500 employees at 56 Medicare contractors have primary responsibility for processing Medicare claims, providing technical assistance to providers and servicing beneficiaries needs, including enrollment and premium billing, and responding to inquiries; (2) 5,900 State employees have primary responsibility for inspecting hospitals, nursing homes, and other facilities to ensure that health and safety standards are met; and

(3) 1,800 employees at 53 Peer Review Organizations conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries. The Administrative expenses also pay for some services provided by the Social Security Administration (SSA), the Railroad Retirement Board (RRB), and other Federal agencies in support of Medicare/Medicaid programs.

MEDICARE

Title XVIII of the Social Security Act was established by the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people aged 65 and over. In 1972, the program was broadened to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and certain others who elect to purchase Medicare coverage.



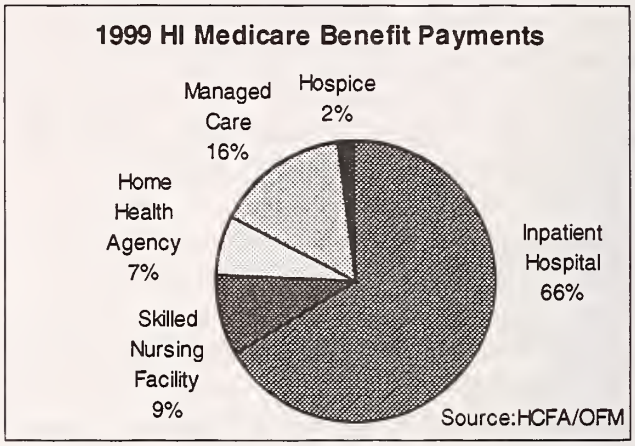
Medicare is a combination of two programs, each with its own enrollment, coverage, and financing--Hospital Insurance and Supplementary Medical Insurance. The Balanced Budget Act of 1997 (BBA) created a third program called Medicare+Choice that provides a choice of health insurance options and, through user fees, provides funding for better consumer information. Since 1967, Medicare enrollment has increased from 19.5 million to 39.5 million beneficiaries.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security, ESRD, or Railroad Retirement benefits. HI pays for hospital, skilled nursing facility, home health, and hospice care.

The HI program is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund and invested in U.S. Treasury securities.

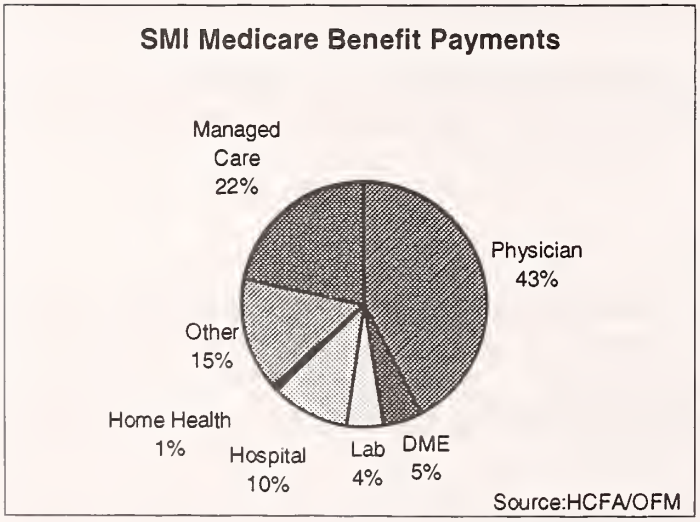
Inpatient hospital spending accounted for 66 percent of HI benefit outlays. Managed care spending comprised 16 percent of total HI spending. HI benefit outlays fell by 3.9 percent. HI benefit outlays per enrollee dropped 4.8 percent to $3,324.



Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over, ESRD beneficiaries, and disabled people entitled to Part A. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy services, and some other services not covered by HI. The SMI coverage is optional and subject to monthly premium payments by beneficiaries. About 95 percent of HI enrollees elect to enroll in SMI.

The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Income not currently needed to pay benefits and related expenses is held in the SMI trust fund, and invested in U.S. Treasury securities.

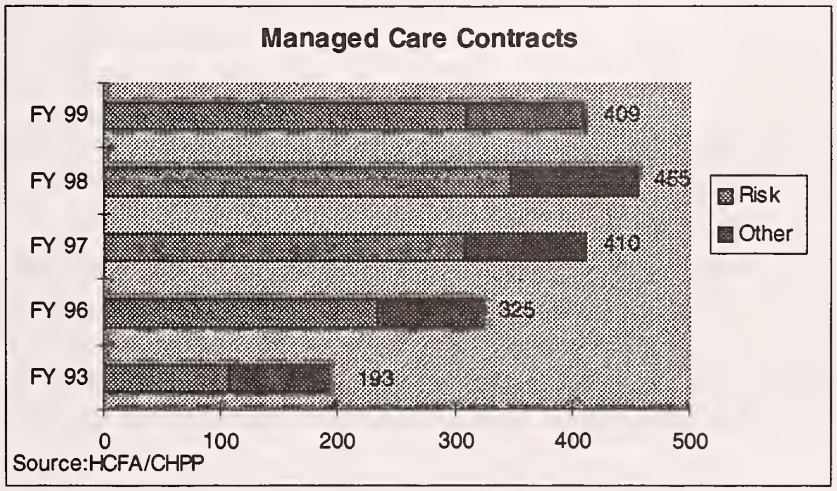


SMI benefit outlays grew by 4.4 percent. Physician services, the largest component of SMI, accounted for 43 percent of expenditures. SMI benefit outlays per enrollee increased 3.7 percent to $2,144.

Medicare+Choice

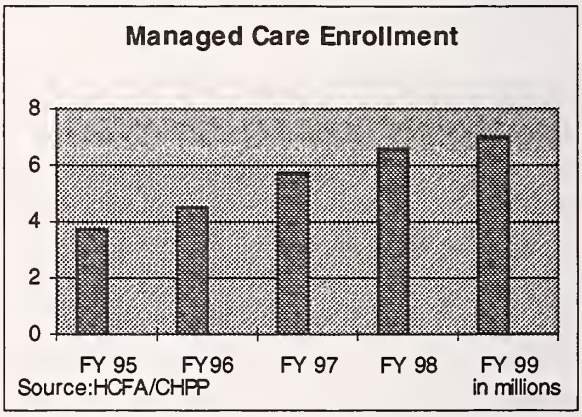
The BBA created a third Medicare program called Medicare+Choice, sometimes referred to as Medicare Part C, to modernize Medicare by expanding the choice of health plan options for Medicare beneficiaries similar to those enjoyed by other Americans. The Medicare+Choice program went into effect in January 1999. With the exception of those with ESRD, any Medicare beneficiary with Part A and B may join a Medicare+Choice organization (M+CO) if one is available in his or her area. At present, beneficiaries may disenroll at any time. The BBA provides for 6 and 9 month enrollment "lock-in" effective in 2002 and 2003, respectively. Enrollment periods vary, but M+COs are required to conduct open enrollment for the November Annual Election Period and allow enrollment to beneficiaries during Initial Coverage Election Periods and Special Election Periods as defined by HCFA.

The BBA's goal is to make Medicare attractive for private entities to provide health insurance choices to beneficiaries. The BBA also restructures the capitation rates for Medicare managed care and provides for a user fee to fund a consumer information campaign to provide beneficiaries with comparative plan information that began in 1998. The number of Medicare contracts with managed care plans increased from 193 in FY 1993 to 409 contracts (coordinated care plans, cost-based contracts, demonstrations, and health care prepayment plans) in FY 1999. Medicare beneficiaries have long had the option to choose to enroll in prepaid health care organizations (typically health maintenance organizations (HMO) and comprehensive medical plans (CMP), commonly referred to as managed care organizations) that participate in Medicare instead of receiving services under traditional fee-for-service (FFS) arrangements. In general, managed care organizations have their own providers or a network of contracting health care providers (physicians, hospitals, skilled nursing facilities, etc.) that agree to provide health care services for the HMO or prepaid health organization's members.



Managed care organizations currently serve Medicare beneficiaries through Coordinated Care Plans (Risk), cost, and health care prepayment plans HCPPs), as well as through certain demonstration projects. Coordinated Care Plans or M+COs are paid a per capita premium, assume full financial risk for all care provided to Medicare beneficiaries, and must provide, at a minimum, all Medicare-covered services. Most M+COs offer additional services such as prescription drugs and eyeglasses at little or no cost to beneficiaries. Cost contractors are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services but do not always provide the additional services that some risk M+COs offer. HCPPs are paid in a manner similar to cost contractors but generally cover only Part B Medicare services. Section 1876c-based contractors and HCPPs, with certain limited exceptions, phase out under the BBA provisions.

Since 1995, Medicare beneficiaries enrolled in managed care plans have increased from 3.7 million to a total of 7.0 million in 1999, which represents 17.7 percent of the total Medicare population. Managed care expenses accounted for $37.4 billion of the total $200.9 billion in Medicare benefit payment expenses in FY 1999.

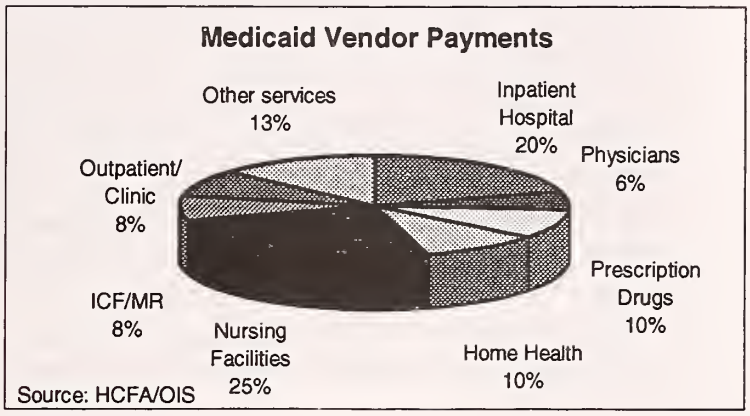


MEDICAID

Medicaid is the means-tested health care program for low-income Americans, administered by HCFA in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly and the blind and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. The average enrollment for Medicaid was 33 million in 1999, about 12 percent of the United States population. Approximately 6 million people are dually entitled, that is, covered by both Medicare and Medicaid.

HCFA provides matching payment grants to States and Territories to cover Medicaid program and administrative costs. State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 1999, the Federal matching rate for Medicaid program costs among the States ranged from 50 to 77 percent, with a national average of 57 percent. Federal matching rates for various State and

local administrative costs are set by statute, and in 1999 averaged 56 percent. Medicaid grants are funded by Federal general revenues provided to HCFA through the annual Labor/HHS/Education Appropriations Act. There is no cap on Federal matching payments to States.



States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include providing coverage to persons receiving Supplemental Security Income (disabled and elderly population), low-income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning, nursing facility services, and health screening for children under age 21. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States.

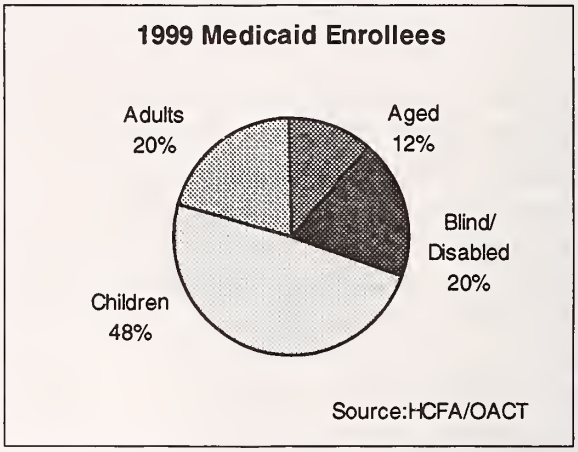
Medicaid is the largest single source of payment for health care services for persons with AIDS. Medicaid now serves over 55 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 1999 was about $3.9 billion. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration for treatment of AIDS.

Payments

Under Medicaid, State payments for both medical assistance (MA) and administrative (ADM) costs are matched with Federal funds. In FY 1999, State and Federal ADM outlays were $9.7 billion--only 5.1 percent of the total Medicaid outlays. State and Federal MA outlays were $180.8 billion, or 94.9 percent of total Medicaid outlays, an increase of over 6 percent over FY 1998. HCFA's Medicaid expenses totaled $109.0 billion.

Enrollees

An estimated 41.9 million persons were enrolled in Medicaid in 1999. Children comprise 48 percent of Medicaid enrollees, but account for only 15 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 32 percent of Medicaid enrollees, but accounted for 65 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.



Service Delivery Options

Many States are pursuing managed care as an alternative to the fee-for-service (FFS) system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of waivers provided by HCFA to introduce managed care plans tailored to their State and local needs, and there are currently 48 States offering a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from slightly under 15 percent in 1993 to an estimated 53 percent by 1999.

HCFA and the States have worked in partnership to offer managed care to Medicaid beneficiaries. Medicaid law provides for two kinds of waivers of existing Federal statutes to allow for the implementation of managed care:

1) State health reform waivers - Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects, and

2) Freedom-of-choice waivers - Section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow States to develop innovative managed health care delivery or reimbursement systems.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

The State Children's Health Insurance Program (SCHIP) was created through the BBA to address the fact that nearly 11 million American children -- one in seven -- are uninsured and therefore at significantly increased risk for preventable health problems. Many of these children are in working families that earn too little to afford private insurance on their own but too much to be eligible for Medicaid. Unfortunately, the number of uninsured children has been rising. Congress and the Administration agreed to set aside $24 billion over five years, beginning in fiscal 1998, to create SCHIP -- the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage for children who already have coverage. Important cost-sharing protections also were established so families would not be burdened with out-of-pocket expenses they could not afford.

The statute sets the broad outlines of the program's structure, and establishes a partnership between the Federal and State governments. States are given broad flexibility in tailoring programs to meet their own circumstances. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches. States can choose among benchmark benefit packages, develop a benefit package that is actuarially equivalent to one of the benchmark plans, use the Medicaid benefit package, or select a combination of these approaches.

States also have the opportunity to set eligibility criteria regarding age, income, resources, and residency within broad Federal guidelines. The Federal role is to ensure that State programs meet statutory requirements that are designed to ensure meaningful coverage under the program.

Making SCHIP a success is one of this Administration's highest priorities. HCFA works closely with States, Congress, the Health Resources and Services Administration and other Federal agencies to meet the challenge of implementing this program and defining its parameters, while at the same time, approving State plans as quickly as possible. HCFA provides extensive guidance and interim instructions so States can develop their plans and start using Federal funds to begin insuring children at the earliest possible date.

As of September 30, 1999, all 50 States, the District of Columbia, and the commonwealths and territories had approved child health plans. Of these, 27 are Medicaid expansions, 16 are separate State child health plans, and 13 are combination plans. In addition, 28 amendments have been approved.

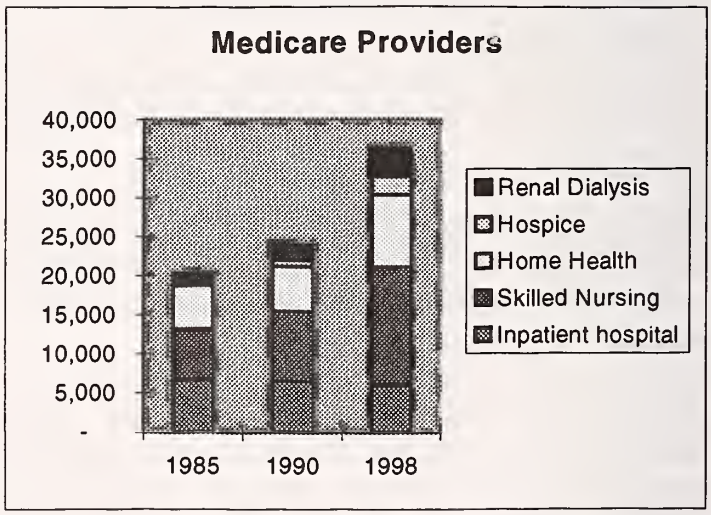
OTHER HCFA ACTIVITIES

In addition to making health care payments on behalf of our beneficiaries, HCFA makes other important contributions to the delivery of health care in the United States.

Survey and Certification Program

HCFA is responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The Survey and Certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. HCFA administers agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments.

Since 1985, there has been a very large growth in providers with the largest increases in skilled nursing facilities, home health agencies, hospices, and end- stage renal dialysis facilities. Certified Medicare providers have increased from about 22,000 in 1985 to nearly 40,000 today. This total does not include the 64,000 clinical laboratories.



Quality of Care

Through Peer Review Organizations, ESRD Networks, State Agencies, and others, HCFA collaborates with health care providers and suppliers to promote the improved health status of Medicare and Medicaid beneficiaries in both FFS and managed care settings. These collaborative projects often employ a sequential process that includes setting priorities, collecting and analyzing data, identifying opportunities to improve care, establishing performance expectations, and selecting and managing one or more improvement strategies. One of the tools for improving patient care is the development and dissemination of quality

indicators and the publication of performance information.

HCFA has been a leader in the use of quality indicators. Our goal is to collect measures that will help to improve the health status of our beneficiaries or help them make informed choices about their health care. Additionally, these quality indicators will assist health care providers in monitoring the care they deliver. This is an area in which we have worked very closely with the private sector, consumers, and providers to develop new tools.

Coverage Policy

In today's health care market, every insurer and health care purchaser must deal with coverage policy. Private as well as public insurers, like Medicare, want to purchase high quality health care for the best price. Health plans, whether public or private, managed care or traditional indemnity plans, must control costs while still continuing to assure the highest quality of care for their subscribers. This cannot be done without authoritative evidence of the value of each individual service. Medicare is a leader in **evidence-based decisionmaking** for coverage policy. We are establishing a new process that will guarantee beneficiary input through a Medicare Coverage Advisory Committee (MCAC). The MCAC holds open meetings and includes consumer as well as industry members. We also rely on state-of-the-art technology assessment and support from other Federal agencies. Our own extensive payment data contain additional useful information that is used by the Agency for Health Care Research Quality (AHCRQ) and others for assessing the effectiveness of a variety of medical treatments. The sheer number of beneficiaries that we serve and the wealth of information that we possess about them makes Medicare an important force in the market.

Insurance Oversight

HCFA has primary responsibility for setting standards for the **Medigap** insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. HCFA works with State insurance counseling offices to ensure that suspected violations of the laws governing the marketing and sales of Medigap are addressed.

HCFA is also responsible for implementing the data standards provision of HIPAA. The administrative simplification provision is aimed at reducing administrative costs and burdens in the health care industry. It requires HHS to adopt **national uniform standards** for the electronic transmission of certain health information. HCFA is working with both public and private organizations to develop the best standards possible with strong safeguards to ensure privacy of records. Although HIPAA does not mandate the collection or electronic transmission of any health information, it does require that adopted standards be used for any

electronic transmission of specified transactions.

As a result of the **insurance reform provisions** of HIPAA, HCFA has assumed a new role in relationship to State regulation of health insurance and health coverage. HCFA works with the States's Commissioners of Insurance, the U.S. Department of Labor and the Internal Revenue Service to implement these provisions. The common goal is to improve access to the group and individual health insurance markets for certain eligible individuals who move from job to job, or who lose their group health insurance coverage and must purchase coverage in the individual insurance market. These new consumer protections affect an estimated 160 million individuals.

Performance Goals

The Government Performance and Results Act (GPRA) of 1993 requires Federal agencies to prepare 5-year strategic plans setting out long-term goals and objectives, Annual Performance Plans (APP) committing to short-term performance goals, and Annual Performance Reports (APR) explaining and documenting how effective the Agency's actions have been at achieving the stated goals.

HCFA's performance measurement approach is based on two principles: (1) the most important things to measure relate to ensuring that HCFA's beneficiaries receive the high quality care they need; and (2) the measures will be representative of program performance.

The APP describes HCFA's performance goals, their linkage to longer-term strategic goals and to the budget, as well as the steps planned and underway to accomplish each goal. The plan also establishes a method and data source for measuring and reporting on each goal. The FY 1999 performance plan includes 18 significant performance goals for HCFA programs designed to provide coverage of major program areas and budget categories.

HCFA's first APR, reporting on our progress on each of these FY 1999 performance goals, was submitted with the President's budget request. A summary of HCFA's FY 1999 goals and their performance is included in this section.

All HCFA performance goals relate to important outcomes such as improved beneficiary health and satisfaction, sound fiscal management of one of the largest budgets in the Federal government, and maximum use of appropriate technology to improve service, increase productivity, and minimize cost. The plan contains performance goals relating to improved use of information technology; effective implementation of Medicare+Choice and other BBA provisions; millennium readiness; reduction in fraud and erroneous Medicare payments; and improvements in quality of care oversight and customer service. It reflects key Administration and Agency priorities for the next several years. HCFA's performance goals reflect a sensitivity to customer needs and an awareness that meeting those needs will require flexibility and imagination as well as sound business sense.

The Office of Management and Budget (OMB) granted HCFA a 1-year waiver of GPRA rules for the Medicaid program for the FY 1999 APP. This provided sufficient time for the Agency to continue a consultation process with State Medicaid officials aimed at producing performance goals of mutual interest. During 1998 HCFA and the States jointly developed a new Medicaid goal that commits HCFA and the States to increase childhood immunization rates over the next several years.

Consistent with GPRA principles, HCFA identified a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as steward of many billions of taxpayer dollars. The Agency is confident that performance measurement under GPRA will contribute substantially to improvement in HCFA's programmatic and administrative performance. We anticipate that performance results will provide a wealth of information about the success of HCFA's programs, activities, and initiatives. This information will be useful in making policy and management choices in both the short and long term.

The following GPRA Performance Goals are grouped by HCFA's Strategic Plan goals.

Goal 1 - Protect and Improve Beneficiary Health and Satisfaction

HCFA has defined "quality of care" as the "extent to which health care and health-related services result in desired outcomes and greater satisfaction with care for the populations and individuals we serve." This definition of quality of care and the mission statement serve as the Agency's foundation for developing an integrated quality program framework.

Improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance. (Goal MMA1-99)

This performance goal focuses on reducing financial barriers to care by increasing the number of individuals who are dually qualified for Medicare and at least some aspect of the Medicaid program. Our emphasis in the initial years of this goal is on increasing enrollment for Medicare beneficiaries who are eligible for the Qualified Medicare Beneficiary (QMB) or the Specified Low-Income Medicare Beneficiary (SLMB) programs.

HCFA's FY 1999 goal to work with States to establish an enrollment target has been achieved. In conjunction with States, a 4 percent increase in enrollment target for FY 2000 has been established. By meeting the target rate of 4 percent in 2000, additional 211,000 beneficiaries will be enrolled in a dual eligible program in FY 2000. The total dual eligible enrollment target for the end of FY 2000 is 5,481,000, which is an overall increase over the 1998 baseline of 314,000. This total enrollment figure represents an average increase over the 1998 baseline of 2 percent for 1999, and an increase of 4 percent in FY 2000.

Improve satisfaction of Medicare beneficiaries with the health care services they receive. (Goal MB1-99)

This goal is to increase the percentage of beneficiaries who are satisfied with the health care services they receive through the Medicare program in both managed care and fee-for-service. Over a 5-year period, starting in FY 1999, HCFA began targeting beneficiaries enrolled in

Medicare managed care plans to increase their ratings of satisfaction with the various components of their health care services. Self-assessed consumer satisfaction with health care is generally recognized as an important measure of quality of care and of health plan performance.

Managed Care

The goal for FY 1999 was to use the newly available baseline Consumer Assessment of Health Plan Survey (CAHPS) data and our knowledge of satisfaction using data from Medicare Current Beneficiary Survey (MCBS) to develop estimated targets. The target was met. Baselines and targets were set for two measures (a and b, below):

a. Getting needed care for illness or injury

Baseline: In 1998, in 74 percent of plans, at least 90 percent of beneficiaries reported that they could usually or always get care for illness or injury as soon as they wanted.

FY 2000 Target: Continue efforts to achieve by 2003, in 79 percent of plans, at least 90 percent of beneficiaries reported that they could usually or always get care for illness or injury as soon as they wanted.

b. Ease of getting referral to a specialist

Baseline: In 1998, in 70 percent of plans, at least 80 percent of beneficiaries reported that it was not a problem to get a referral to a specialist that they needed to see.

FY 2000 Target: Continue efforts to achieve by 2003, in 75 percent of plans, at least 80 percent of beneficiaries reported that it was not a problem to get a referral to a specialist that they needed to see.

Fee-for-Service

Continue to develop an appropriate performance measurement and reporting methodology, including CAHPS-like measures that can be used to assess beneficiary satisfaction. (Developmental)

The target was met. Development continuing with survey to be fielded in the fall of 2000 (FY 2001). Baseline data for beneficiaries in fee-for-service will become available in calendar year 2001.

Increase the percentage of Medicare beneficiaries age 65 years and older who receive an influenza (flu) vaccination. (Goal QP2-99)

Influenza is a potentially life-threatening, but preventable, respiratory disease. It is estimated that 10,000-40,000 persons die each year in the United States from influenza and related

complications. Many common health conditions in the elderly are worsened by the flu, and an annual influenza vaccination is recommended for all persons age 65 years and older. Given the importance of this immunization, and HCFA's role in encouraging it, increasing the percentage of Medicare beneficiaries receiving an annual flu shot is an important life-saving outcome goal.

Interim data indicates we achieved a rate of 63 percent. Our FY 1999 target was 59 percent. Final data are expected Spring/Summer 2000.

Increase the percentage of Medicare beneficiaries age 65 years and older receiving a mammogram. (Goal QP3-99)

A mammogram is a safe, low-dose x-ray of the breast and is the most effective means of detecting breast cancer while it is still in an early treatable stage. Studies show a clear link between mammography's early detection and improved health outcomes. Since older women face a greater risk of developing breast cancer than younger women, HCFA's efforts for encouraging regular mammograms is critical to reducing breast cancer deaths among women of Medicare age.

The FY 1999 target was to increase bi-annual mammograms in women age 65 and older to 59 percent. The data for reporting progress toward our goal has been delayed (1998 NHIS), and are not expected to be available until Spring/Summer 2000. Secondary data sources indicate positive trends in mammography rates for women age 65 and over.

Decrease number of uninsured children by working with States to implement State Children's Health Insurance Program (SCHIP) and increase enrollment of eligible children in Medicaid. (Goal CHIP1-99)

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP). This program makes an unprecedented investment toward improving the quality of life for millions of vulnerable, uninsured, low-income children. States were given the option to expand their Medicaid program, establish a separate SCHIP program or a combination of both. By September 1999, all 56 SCHIP plans submitted by the States and territories were approved and many States have already submitted amendments in order to further expand insurance coverage under SCHIP.

We achieved our FY 1999 goal, which was to work with States to develop a FY 2000 Annual Performance Plan goal related to decreasing the number of uninsured children and enrolling eligible children in Medicaid. Our FY 2000 goal is to increase the number of children who are enrolled in regular Medicaid or SCHIP by 1 million over the previous year.

Goal 2 - Promote Fiscal Integrity of HCFA Programs

The passage of the HIPAA and the BBA has a tremendous impact on the fiscal integrity of HCFA's programs. Implementation of the provisions contained in these laws will provide continuing impetus toward sound financial management and the elimination of fraud, waste, and abuse in Medicare.

Improve HCFA's rating on financial statements. (Goal MCIC4-99)

This goal commits HCFA to corrective actions in the areas of financial management cited in the Office of Inspector General (OIG) audit of HCFA's FY 1996 financial statement. Because HCFA represents more than 80 percent of HHS outlays, it is important to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible. Auditing of the statements ensures that the numbers included are reasonable by reviewing the full spectrum of financial operations, internal controls, and compliance with laws and regulations at HCFA and at its agents. HCFA's goal was to achieve a clean opinion for FY 1999.

We have achieved our FY 1999 goal and our auditors have confirmed the progress that we have made by providing us with our first clean audit opinion on our FY 1999 Financial Statements. We will do everything necessary to maintain our clean financial statement opinion for FY 2000.

Reduce the percentage of Medicare home health services provided for which improper payment is made. (Goal MIP5-99)

HCFA will develop and implement tools to fight fraud and abuse in the Medicare home health program that will: strengthen the Agency's ability to identify problem home health agencies; prevent them from entering the program; reduce losses to the Medicare program due to problem home health agencies; and, prevent inappropriate payments to providers by restructuring coverage and payment for home health services.

The target for this goal is to reduce the percent of home health services provided for which improper payment is made from 40 to 35 percent in California, Illinois, New York, and Texas by FY 1999. OIG Final Report: *Review of Medicare Home Health Services in CA, IL, NY and TX (A-04-9901194)*, issued November 1999, reports that the error rate was reduced to 19 percent. This goal has been achieved.

Reduce the percentage of improper payments made under the Medicare fee-for-service program. (Goal MIP1-99)

The purpose of this goal is to continue to reduce the percentage of improper payments made under the fee-for-service program. One of HCFA's key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

The target for this goal was to achieve a 9 percent error rate for Medicare fee-for-service. In FY 1999, the error rate was 7.97 percent; in FY 2000 we expect to continue to reduce the percentage of incorrect payments.

Goal 3 - Purchase the Best Value Health Care for Beneficiaries

HCFA is the largest purchaser of health care in the United States, and is transitioning from a payer organization to a "prudent purchaser of health care services." This transition is being made through collaboration with a number of large purchasers to explore opportunities for obtaining the best value in quality, cost-effective health care services for our beneficiaries. To that end, we have created a user-friendly system that will enable HCFA to deal with our provider groups and advocacy communities and will enhance coordination of customer correspondence, report gathering and research.

Along with other large purchasers of health care, we are developing purchasing strategies that will help us not only meet our goal of providing high quality health care to both Medicare and Medicaid beneficiaries, but also provide the best value in services for the dollars we spend for both managed care and fee-for-service.

Decrease the prevalence of restraints in long-term care facilities. (Goal QSC1-99)

The prevalence of the use of physical restraints is an accepted indicator of quality of care, and considered a proxy for measuring quality of life for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. Many providers and consumers still mistakenly hold, however, that restraints are necessary to prevent residents from injuring themselves.

We have achieved the FY 1999 goal to decrease the prevalence of the use of physical restraints to 14 percent. Current data show that the prevalence of physical restraint use is 11.7 percent for FY 1999.

Increase health plan choices available to Medicare beneficiaries. (Goal MB2-99)

This goal was designed to ensure that Medicare beneficiaries have a choice of high quality health care options in both fee-for-service and managed care. We believe that expanded competition in the marketplace promotes quality, expands benefits, controls price, and stimulates innovation.

We did not achieve the target for this goal. The number of new applications or service area expansions did not materialize. In addition, there were 45 Managed Care Organizations (MCOs) that terminated their contracts and 54 MCOs that reduced their service area at the beginning of 1999, resulting in 79 counties not served by having a managed care option/choice. Final data for FY 1999 indicate 76 percent of Medicare beneficiaries had at least one managed care option/choice available to them. Achievement of this goal is dependent upon receiving applications from rural areas and areas where there are no managed care organizations, which contributed towards HCFA not meeting the FY 1999 target. HCFA has revised the target to reflect changes in the market.

Goal 4 - Promote Beneficiary and Public Understanding of HCFA and its Programs

Please refer to the APP Goal for Beneficiary Satisfaction under HCFA Strategic Plan Goal 1. Relevant activities in achieving beneficiary satisfaction result in a promotion of beneficiary and public understanding of HCFA and its programs.

Goal 5 - Foster Excellence in the Design and Administration of HCFA's Programs

HCFA has embarked on a number of systems enhancements and innovations. As discussed earlier, some of these initiatives will not be implemented until Y2K compliance is assured.

Increase the use of electronic commerce in Medicare. (Goal MCIC3-99)

The objective of this performance goal is to increase the percentage of activities accomplished electronically, rather than on paper form or on the telephone. These activities consist of: electronic remittance advice, electronic funds transfer, electronic claims status, electronic eligibility inquiry, and electronic media claims (EMC). HIPAA requires the adoption of standardized electronic formats and data contents for claims, coordination of benefits, remittance advice, claims status inquiry/response, and eligibility inquiry/response. Increasing standardization and increasing the percentage of transactions performed electronically will increase the efficiency of the Medicare contractors and save Medicare administrative dollars.

With a FY 1997 baseline estimated EMC rate of 96.1% for intermediaries and 79.4% for carriers, HCFA created a FY 1999 target for EMC of 97% for intermediaries and 80% for carriers. Primary data sources indicate that HCFA will meet this target.

Enroll beneficiaries into managed care plans timely. (Goal MB3-99)

It is vital that the system records enrollments timely for many reasons. If the enrollment is not recorded timely, beneficiary medical coverage and managed care plan payments are affected. In the absence of timely enrollment, the beneficiary's election is not in force but the organization must provide managed care services for which they will not receive a timely capitated rate for that member. If the beneficiary is a member of an Employer Group Health Plan (EGHP), adjustments to the capitated payments must be made to account for the months the beneficiary should have been recorded as a member.

Improvements in the timeliness of enrollment processing will reduce beneficiary confusion regarding the status of their medical coverage, reduce fee-for-service claims processing errors, and reduce provider frustrations regarding payment. This performance goal measures the timeliness of HCFA systems processing of enrollment transactions received from managed care organizations for Medicare beneficiaries.

The target of this goal is for 98 percent of clean Medicare+Choice organization enrollment transactions received in compliance with the monthly processing schedule (generally the first Tuesday or Wednesday of each month), the system will update beneficiary records with enrollment effective dates equal to the effective dates on the transactions. For 98 percent of Medicare+Choice organization enrollment transactions received for the November open period, the system will update beneficiary records with enrollment effective dates as of the first of the following January. Final data will not be available until Spring of 2000.

Ensure millennium compliance (readiness) of HCFA computer systems. (Goal MCIC3-99)

This goal tracks HCFA's success in converting its computer systems to ensure millennium compliance (readiness to process the new dates occurring around the Year 2000). Certification of millennium compliance by appropriate authorities is the measure of millennium readiness. For FY 1999, HCFA's target was to ensure that no significant interruptions to Medicare claims payments will occur due to the lack of Year 2000 compliance of information systems under HCFA's direct control. For systems not under HCFA's direct control, HCFA will continue to work with its Medicare contractor community and perform oversight activities directing them to achieve compliance and verify that it has occurred.

HCFA achieved this goal. We did not experience any systems disruptions during the Y2K transition.

Develop new Medicare payment systems in fee-for-service and Medicare+Choice. (Goal AC4-99)

This goal was designed to implement statutory requirements within time frames specified in law, to improve our ability to be a beneficiary-centered purchaser, to develop additional prospective payment systems, and to refine payments to Medicare+Choice plans by adjusting for beneficiary health status.

This goal was not fully met. The Outpatient Prospect Payment System was delayed due to Y2K activities that affected this goal. However, HCFA implemented the Skilled Nursing Facility Prospective Payment System in July 1998, and the Report to Congress on the risk adjustment methodology was delivered on schedule.

Goal 6 - Provide Leadership in the Broader Public Interest to Improve Health

Improve laboratory testing accuracy. (Goal CLIA1-99)

Proficiency testing provides a means of measuring a laboratory's performance. These tests will increase patient and physician confidence in a particular laboratory by producing a snapshot of the laboratory's ability to perform tests accurately according to objective standards. They also reduce the need for repetitive testing and thereby reduce overall costs of medical care related to diagnostic testing.

Final data indicate that we were just shy of meeting our target percentages for FY 1999: 90 percent of enrolled have no failures and 95 percent of labs are enrolled in the program. The data showed that 88.6 percent of the scores from laboratories had no failures and 94.4 percent of the laboratories that should be enrolled in proficiency testing were properly enrolled. We plan to sustain the FY 1999 targets through FY 2000.

Provide to States linked Medicare and Medicaid data files for dually eligible beneficiaries. (Goal MMA3-99)

This goal was designed to provide a complete picture of joint Medicare and Medicaid service utilization and expenditures and to develop linked Medicare and Medicaid data files on dually eligible beneficiaries. There are approximately 6 million individuals dually eligible for Medicare and Medicaid at some point during the year. Although dually eligible beneficiaries represent about 16 percent of the Medicare population, they represent 30 percent of total

Medicare expenditures.

Through continuous innovation and reform in the Medicare and Medicaid programs, HCFA hopes to foster a service delivery system that is better integrated and more flexible in meeting the needs of dually eligible beneficiaries. To accomplish this, policy makers, researchers, and others need information on the dual eligible population. Therefore, in FY 1999, HCFA developed a target to make Medicare data available to 27 States for their use in linking to Medicaid data.

Final data for FY 1999 indicates that we have met the target and made the Medicare data available to 27 states, upon request, for their use in linking to Medicaid data.

Develop a method for assessing the relationship between HCFA research investments and program improvements. (Goal R1-99)

The purpose of HCFA's research program is to provide HCFA and the health care policy community with objective analyses and information to foster improvement in HCFA programs and to guide the Agency in its future direction. HCFA's research and development functions are to develop, test and implement new health care financing policies, and to monitor and evaluate the impact of HCFA's programs on its beneficiaries, providers, States and other customers and partners.

The FY 1999 goal was to develop a method for assessing the relationship between research investments and program improvements for inclusion in the FY 2000 Annual Performance Plan. A methodology was developed and activities for establishing the baseline internal and external performance assessments began in 1999 and will continue in 2000.

Work with States to develop Medicaid program performance goals. (Goal MMA2-99)

Medicaid is a Federal-State partnership designed to provide health care to low-income Americans. Developing performance measures on Medicaid topics is especially challenging because it is a State-run program, and State cooperation in the measure is voluntary.

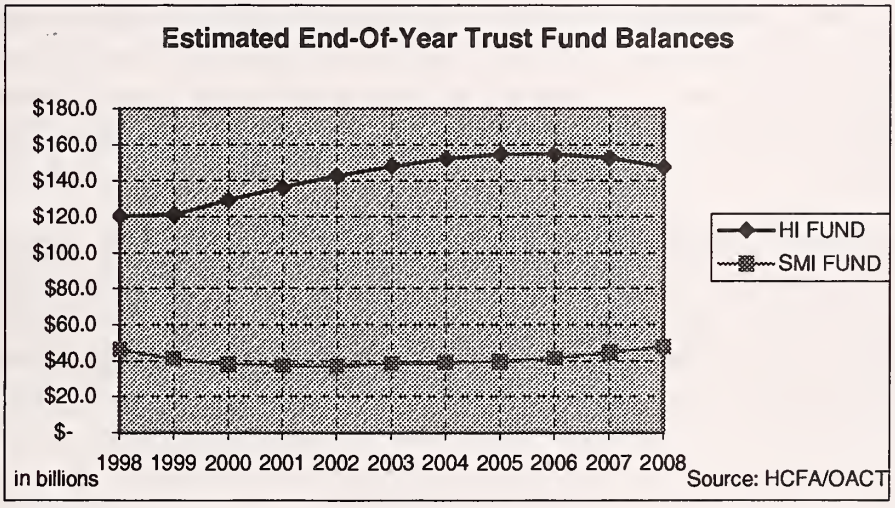
The FY 1999 goal was to work with States to develop Medicaid performance goals for inclusion in the FY 2000 Annual Performance Plan. This effort resulted in the development of the childhood immunization goal. Three groups of States staggered over 3 years, will begin developing baselines, methods, and targets to increase childhood immunization rates for their State's Medicaid two-year olds. In FY 1999, HCFA sponsored meetings, conducted site visits, and provided technical assistance to the first group of States to begin developing their measurements.

Challenges and Other Initiatives

Status of the Trust Fund

Hospital Insurance (HI)

The *1999 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund* projected, under intermediate actuarial assumptions, that the HI Trust Fund will be depleted in 2015.



The estimates shown in the table represent a substantial improvement from those shown in the 1998 annual report. The improvement arises from higher payroll tax revenues in 1998 than had been estimated and lower benefit expenditures. Lower HI expenditures reflected the implementation of the Balanced Budget Act of 1997 (BBA). In addition, there were lower increases in health care costs than previously predicted combined with continuing efforts to combat fraud and abuse.

The Trustees (the Secretaries of the Treasury, HHS, Labor, the Commissioner of the SSA, and two public trustees) recommend that the time gained by the later depletion of the HI trust fund be used productively to determine effective solutions to the remaining long-range problems. Prompt, effective, and decisive action is necessary to build upon the strong steps taken by the BBA.

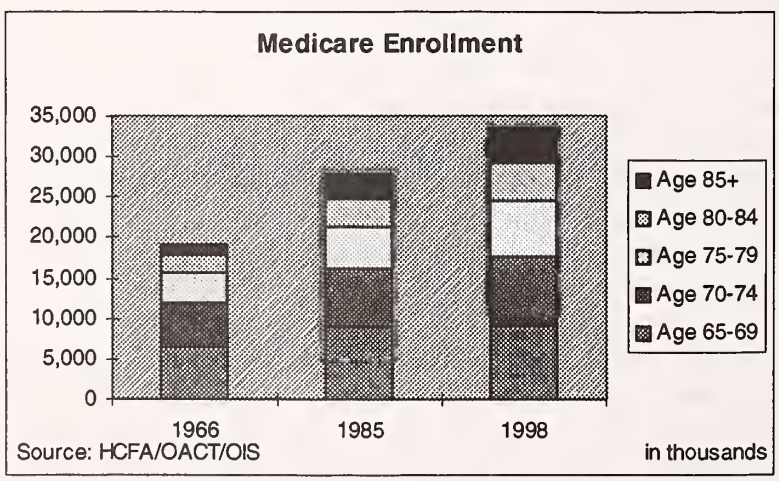
Supplementary Medical Insurance (SMI)

The SMI trust fund is expected to remain adequately financed into the indefinite future. Current law provides for the establishment of program financing each year based on an updated calculation of expected cost per SMI beneficiary. The Trustees note with great concern the past and projected rapid growth in the cost of the program and urge the nation's policy makers to continue to consider effective means of controlling SMI costs.

The Demographic Challenge - Medicare

Demographic trends pose a long-term challenge to the sustainability of the trust funds. There are expected to be 3.6 workers per HI beneficiary when the baby boom generation begins to reach age 65 in 2010. Then the worker/beneficiary ratio is expected to decline to 2.3 in 2030 as the last of the baby boomers reaches age 65. The ratio is expected to continue declining thereafter (but more gradually) as life expectancy continues to lengthen. HI expenditures are projected to grow rapidly as a fraction of workers' earnings, from 3.2 percent in 1998 to about 6.8 percent in 2070. As a fraction of the Gross Domestic Product (GDP) HI expenditures would grow somewhat more slowly, from 1.6 percent in 1999 to about 3.0 percent in 2070.

SMI benefits have generally been growing rapidly although rates of growth have moderated in recent years. Outlays have increased 41 percent over the past 5 years. During this period the program grew about 9 percent faster than the economy as a whole, despite efforts to control SMI costs. SMI expenditures are expected to continue to grow faster than the economy as a whole. SMI outlays were less than 1 percent of the GDP in



1999 and are projected to grow to about 1.97 percent by 2070. Since 1966, the Medicare Part A beneficiaries ages 85 and over have increased from 6.2 percent to 12.2 percent of all aged beneficiaries enrolled in HI.

Disbursements as a Percent of GDP

Calendar Year	HI	SMI	Total
1999	1.56	0.98	2.54
2000	1.56	1.05	2.61
2005	1.58	1.21	2.79
2020	1.95	1.97	3.92
2070	3.02	2.65	5.67

Note: SMI as a percent of GDP will grow larger because of the shift of HHA from HI to SMI. Also, Outpatient PPS picks up a larger share of payments in the out years.

Program Integrity Strategy

HCFA has made great strides in 1999 to further define and implement its overall strategy for reducing payment errors in the Medicare and Medicaid programs. Our program integrity strategy focuses on four key payment safeguard principles: Prevention, Detection, Enforcement, and Coordination. **Fraud prevention** means paying right the first time through such measures as changing Medicare payment methodologies to make it harder for fraud to occur, keeping convicted criminals out of the program, and requiring providers to post surety bonds. We collect information that allows us to track abusive providers. **Detection** means catching and recovering improper payments quickly by analyzing our data, monitoring utilization trends, and following-up on beneficiary reports of improperly paid claims. **Enforcement** means taking action through administrative remedies against those who abuse the Medicare and Medicaid programs. Those actions include suspending payments, collecting overpayments, disenrolling bad providers, imposing civil monetary penalties, and/or referring cases to the OIG. **Coordination** means providing case support for law enforcement, developing fraud alerts and fraud databases, and working with beneficiaries and providers to reduce payment errors.

In February 1999, we released our first Comprehensive Plan for Program Integrity that highlights HCFA's goals and overall strategy for reducing payment errors in the Medicare and Medicaid programs. We have made great strides in meeting the goals we outlined. Ten initiatives focus on program management improvements and on service specific areas where we need to strengthen oversight and develop new program integrity

strategies. The program integrity initiatives as defined in the Comprehensive Plan are as follows:

Increasing the effectiveness of our medical review and benefit integrity activities
We have increased the overall level of medical review, developed improved performance standards for contractor program integrity activities, and conducted training for HCFA and contractor staff to enhance the quality of fraud case referrals.

Implementing the Medicare Integrity Program
HCFA awarded Medicare Integrity Program contracts to thirteen Program Safeguard Contractors (PSCs). We awarded six task orders to those PSCs as described in the "Medicare Integrity Program" section below.

Implementing payment safeguards for new Balanced Budget Act provisions
Our current Medicare contractors have implemented several automated safeguards to ensure new programs and benefits are paid properly. We are also developing medical review standards as the new prospective payment systems are implemented, identifying vulnerabilities and developing mitigation plans.

Promoting provider integrity
We are developing stricter standards and stronger conditions of participation, conducting on-site visits to verify legitimacy and compliance with standards, requirements to program entry, creating a national provider enrollment database, establishing surety bond requirements, collecting Social Security Numbers to improve accountability, and collecting better ownership and financial solvency information.

Initiating millennium contingency planning for program integrity activities
HCFA had developed millennium contingency plans to address potential Year 2000 related risks. For example, we awarded a Program Safeguard Contract to Computer Sciences Corporation to perform Y2K data analysis, identify millennium-related aberrancies, and conduct provider on-site reviews, as necessary.

Addressing service specific vulnerabilities
Inpatient hospitals: Inpatient hospital claims comprised about 20 percent of the errors identified in past CFO audits which involve a significant dollar amount. HCFA has developed a multi-faceted corrective action plan to reduce those errors, including the Payment Error Prevention Program and a series of pilot efforts to investigate, correct, and prevent improper claims.

Congregate care facilities: Groups of beneficiaries gathered in one place, such as a skilled nursing facility or an assisted living facility, are easy targets for unscrupulous providers. We have developed a diverse approach that includes a data analysis model to

identify abusive situations and a pilot project to develop contractor procedures to review claims and collect overpayments when appropriate.

Managed care plans: These plans involve a different set of financial incentives for providers and thus a different set of fraud and abuse concerns. We are developing a special statement of work for a Medicare Integrity Program contractor to focus on managed care fraud and abuse issues. In the interim we will audit data that the managed care plans report to us to formulate their reimbursement levels to ensure that they are providing necessary and appropriate services to beneficiaries.

Community mental health centers: HCFA has developed and implemented a 10-point plan to strengthen its oversight of the Community Mental Health Center (CMHC) benefit. We are conducting site-visits to assess the compliance of CMHCs with Medicare rules; issuing clarification of the requirements applicable to CMHCs entering the program; subjecting new applicants to initial site reviews that will be performed by a Program Safeguard Contractor; intensifying medical review for partial hospitalization claims; and, increasing audits of CMHC cost reports.

Nursing homes: HCFA has taken several steps to improve the quality of care in the nursing home setting. We are imposing sanctions more swiftly and increasing the number of site inspections for repeat offenders; enhancing federal review and training for State inspection agencies; and continuing to build our national automated data systems.

Strategies to Improve the Value of Error and Fraud Rates

HCFA is developing methods to project more precise error and fraud rates for the fee-for-service Medicare program through analysis of both pre and post pay claims at the contractor level and below. The Comprehensive Error Rate Testing (CERT) program will produce a paid claims error rate at each contractor, by provider type, and service category levels. The Provider Compliance Rate (PCR) will provide an estimate of the accuracy of claims submitted by providers. A pilot Fraud Rate Project will enable contractors to determine the level of fraud prevalent among providers in their service areas. Additionally, a pilot Payment and Denial Verification Project conducted through HCFA's Regional Office in Boston will provide a more extensive review of a single contractor's claims and calculate error rates according to specific bill types. HCFA has included this as a FY 2001 GPRA goal.

The Medicare Integrity Program (MIP)

As a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which established the "Medicare Integrity Program", HCFA can now competitively

award contracts with entities to promote the integrity of the Medicare Program. The competitive process ensures the highest quality for the best price, using appropriate clinical personnel. These specialized contractors with experience in program integrity activities will increase efficiency and effectiveness, and consistency in application of Medicare coverage and coding rules. Establishing organizations that focus on program safeguard activities separate from the mainstream of claims processing operations is a solution to a potential conflict of interest and a prudent business practice.

In FY 1999, HCFA awarded six PSC task orders to:

Perform Millennium-Related National Data Analysis and Provider On-Site Reviews
PSCs will conduct national data analysis to minimize the potential risk of increased fraud and abuse during the millennium critical months. They will also conduct Coordinated Comprehensive Provider Reviews on providers determined to be a potential fraud risk.

Establish a Part A Benefit Integrity Support Center in New England
A PSC will focus on doing Part A data analysis and supporting fraud unit activities in New England. This will be in support of the current New England Medicare fraud units who will continue their current functions.

Conduct On-Site Community Mental Health Center (CMHC) Reviews
Qualified mental health professionals will conduct uniform, professional, and unannounced on-site visits to CMHCs. These will serve as a tool for screening applicants and enrollees in the Medicare program.

Review Providers for Compliance with OIG Corporate Integrity Agreements (CIAs)
PSCs will perform on-site reviews of providers that are subject to CIAs as part of a settlement with the OIG. They will review the providers' CIA obligations and conduct a statistically sound review of claims to ascertain if the provider is meeting all of their CIA commitments.

Develop a Nationally Focused Medicare Integrity Plan Provider Education Plan
The PSC will conduct a national education needs assessment of our current contractors, providers, and medical and professional groups. They will develop a comprehensive MIP educational plan based on the results of the survey.

Conduct Home Office Cost Report Audits of Large Chain Facilities
This is designed to supplement the efforts of Medicare Fiscal Intermediaries by conducting up to five field audits on Home Office of large Chains who provide services throughout the country.

In FY 2000, we will award a PSC task order to operate the Statistical Analysis contractor functions. Those functions provide Medicare contractors with state of the art tools and systems for detecting Medicare payment errors.

Payment Error Prevention Program

The Peer Review Organizations' (PROs) main goals are to improve quality of care for beneficiaries by ensuring that care meets professionally recognized standards, to protect the integrity of the Medicare program, and to protect beneficiaries through investigation of individual complaints and outreach and education activities.

Under the new contracts that began in August 1999, HCFA has directed the PROs to increase their focus on ensuring Medicare hospital inpatient claims are billed and paid appropriately. As part of the Comprehensive Plan for Program Integrity (Plan), the PROs' Payment Error Prevention Program (PEPP) is directed at acute care hospitals operating under the Prospective Payment System. Under these new contracts, the PROs are slated to spend about 30 percent of their efforts on PEPP.

HCFA is developing a monitoring system to estimate the payment error rate independently within each State, or PRO area. This monitoring system will be continuous in nature and will produce periodic estimates. The PROs will be required to conduct an analysis to identify the nature and extent of payment errors occurring in their area. On the basis of this analysis, the PROs will be expected to implement appropriate educational interventions aimed at changing provider behavior and decreasing the observed payment error rate.

The incentives for PEPP will be an award bonus, to be paid at the end of the contract period. It is based upon the reduction in payment error observed in each PRO area. The overall target for the three-year contract period is a 50 percent reduction in the payment error rate. The target will be adjusted for each PRO using the baseline payment error rate found in each State.

Our corrective actions thus far have been concentrated on increasing levels of claims reviews across a number of broad categories. Now, we need to focus in and customize efforts to address different kinds of payment errors in different ways.

<u>More measurement to tell us where to focus efforts</u>
We will be implementing a new measurement program this year, the Comprehensive Error Testing Program, or CERT. This will provide payment error rates at individual contractors, and allow us flexibility to devise payment error rates for benefit categories.

This targeted information will give us more data to use in focusing our efforts and understanding where errors occur, and why.

Continued efforts under our Comprehensive Plan
This year will mark the start up year for our PEPP for hospitals. It will also be the first full year of operation for our new program integrity contractors, who will help us devise new approaches and innovations in fighting fraud, detecting payment errors, addressing problem areas, and working with our providers through education and feedback.

Looking towards the future
While we learn from the past, we will also spend a significant amount of resources and energy in adopting proactive strategies for integrity as we move into a Medicare modernized for the 21st century. Last year, we instituted a new payment method for skilled nursing facilities. This year, we will be adopting new systems for outpatient departments and home health agencies. As we implement these systems, we are designing monitoring systems to ensure the accuracy of payments and provide more immediate feedback on errors to our providers. More vigorous oversight for nursing homes, enhanced standards for home health and durable medical equipment suppliers, a robust program for oversight of Medicare contractors, and new competitive projects for procuring services and supplies will help further strengthen the program and protect our beneficiaries.

Working with our Partners

Medicaid Initiatives

As part of the National Medicaid Fraud and Abuse Initiative, HCFA will continue to assist the OIG, the State Medicaid Fraud Control Units (MFCU), and Program Integrity Units in their role of prosecuting fraudulent providers. We also ensure all States are aware of fraudulent activities and scams occurring nationwide; promote consistency by establishing enhanced communications systems; form a National Fraud and Abuse Technical Advisory Group composed of HCFA and State agencies; and develop a model legislative fraud and abuse package for States that builds on the best practices of States who already have similar legislation. HCFA has also placed greater emphasis on Medicaid fraud through formation of the Medicaid Fraud and Abuse Coordinating Council and the Medicaid Regional Office Network.

Medicare Secondary Payer (MSP)

If Medicare records fail to show when a beneficiary has other insurance, Medicare can mistakenly pay claims that should have been paid by the primary insurance company. HCFA has undertaken a number of initiatives to avoid incorrect payments in this

situation. The Initial Enrollment Questionnaire solicits data about other primary health insurance coverage from newly enrolled Medicare beneficiaries. A data match, in collaboration with the Internal Revenue Service and the Social Security Administration, is used to develop leads where Federal tax returns show wages reported for beneficiaries or their spouses who might have group health insurance and for whom Medicare is paying for health care services.

In addition to current data match activities, HCFA awarded a 5-year coordination of benefits contract to Group Health Incorporated in November 1999. The Coordination of Benefits contractor will provide a central, standardized methodology for gathering and disseminating MSP data, thus reducing duplication of effort, improving the accuracy of MSP data, and providing better customer service to all of our internal and external partners. The contractor will immediately begin consolidating activities to support the collection, management and reporting of all Medicare beneficiary health insurance coverage information. The contractor will also assume responsibility from intermediaries and carriers for general MSP claims development and trauma code development.

Medicare Contractors

Medicare contractors play an important partnership role with HCFA in safeguarding the fiscal integrity of the Medicare trust funds. HCFA assesses and improves effectiveness and quality of contractor performance through Contractor Performance Evaluation (CPE). In FY 1999, CPE was redesigned as a multi-faceted process to strengthen contractor oversight and includes developing clear and measurable contractor performance standards, employing risk analysis to prioritize contractors for review, instituting greater consistency in the review process by use of central office-regional office or multi-regional review teams, and developing and applying standard business function protocols.

Review teams consisting of central and regional office HCFA staff conducted the following onsite reviews of critical business functions at higher risk contractors:

- Medical review, benefit integrity, and implementation of the interim payment system were evaluated at the five Regional Home Health Intermediaries;

- Medical review, benefit integrity, and audit and reimbursement were evaluated at Mutual of Omaha which services providers in 48 states;

- Medical review, benefit integrity, customer service, and inquiries and appeals were evaluated at the 4 Durable Medical Equipment Regional Carriers.

HCFA staff also performed evaluations of certain other business functions at all contractors doing business with HCFA in FY 1999. The functional areas included Millennium compliance; accounts receivable reporting on the HCFA 750/751; claims processing timeliness; audit quality of Medicare provider cost reports for fiscal intermediaries; timeliness of target rate adjustments; mandated customer service activities; contractor customer service plans; and implementation of HCFA instructions. In addition, HCFA conducted follow-up reviews to verify correction of the deficiencies identified in 1998.

We took noteworthy steps toward better management in our CPE process during the latter half of FY 1999. We required RO submittal of plans for contractor evaluations in FY 1999, as well as monthly improvement plans for FY 1998 deficiencies. We also took steps to improve consistency by issuing a template for preparing the CPE reports for functional area evaluations. Along with that template was guidance on completing the CPE report and use of standard terminology describing problem performance.

While steps taken during FY 1999 have been significant, we recognized that more progress is needed. In September 1999, we contracted with a consulting firm to assist us in establishing a continuous improvement process for all aspects of CPE. With their assistance, we will identify best practices and lessons learned from the FY 1999 CPE reviews, and move forward to expand and improve the CPE process in future years.

A plan known as the Telephone Customer Service strategy was developed which addresses improvement recommendations for Customer Service delivery at the Medicare contractors. The Telephone Customer Service strategy builds upon industry best practices and gives HCFA a method of ensuring consistency, accuracy, and comprehensiveness of information provided to beneficiaries in a cost effective manner.

HCFA has also made great strides in laying the groundwork for nationwide implementation of several of the strategic initiatives, including the Telephone Customer Service, Quality Call Monitoring, Beneficiary Satisfaction Survey, and Performance Measurement.

Partnering with States to Regulate Health Insurance

HCFA has long been responsible for regulating and monitoring Medigap insurance. As a result of HIPAA implementation activities for health insurance portability, HCFA has assumed a new role in relationship to State regulation of health insurance and health coverage. We work closely with the States and the NAIC to get their views and comments on the policy issues and regulatory processes. Also, we met with many other State groups, such as the National Governors' Association and the American Public Welfare Association's National Association of State Medicaid Directors.

The HIPAA provides for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets. The law provides for shared responsibilities for the Secretaries of HHS, Labor, and Treasury. HHS, through HCFA, is working with the other Departments in implementing the group market provisions. In addition, HCFA has the sole responsibility for implementing and overseeing the provision of insurance protection in the individual market.

The group market provisions of HIPAA affect group health plans (generally, plans sponsored by employers or employee organizations, or both, and insurers). These HIPAA provisions are designed to improve the availability and portability of health coverage by limiting exclusions for preexisting conditions; providing credit for prior health coverage; providing new rights that allow some individuals to enroll for health coverage when they lose other coverage or have a dependent; prohibiting discrimination in enrollment and premiums; guaranteeing availability of health insurance coverage for small employers and renewability of coverage in both the small and large group markets.

HIPAA provides for the enforcement of the small group and individual market provisions by States. However, if a State fails to enforce the Federal statutory provisions and does not choose to implement an acceptable alternative mechanism, then the statute provides for Federal enforcement of these provisions. To date, three States-California, Missouri, Rhode Island-have not passed conforming legislation, thus requiring HCFA to assume enforcement responsibility. Other States have opted not to implement some aspect of the insurance reform, thus requiring the Federal Government to assume a more active role.

In 1999, HCFA issued three bulletins to States and issuers conveying HCFA's position on inconsistent insurance practices under group health plans; assuring the rights of "eligible individuals" to guaranteed availability of health insurance coverage in the individual market; and defining several issues related to employer group size in the group market. HCFA has also provided technical assistance to States and others working to implement HIPAA's portability protections. Additionally, HCFA has helped hundreds of consumers resolve their HIPAA-related issues and exercise their rights under the statute.

In order to implement and enforce HIPAA provisions, HCFA, among other things, must collect and review documentation regarding policy forms for compliance, regulate certificates of prior creditable coverage, and monitor marketing of individual policies. We have been working closely with State officials so that workers and their families in these States can benefit from this law as soon as possible.

Improving the Health of Beneficiaries

Coverage

One of HCFA's greatest challenges in administering the Medicare program is to maintain a dynamic decision making process that produces consistent coverage guidance in the face of rapid changes in medical technology and health care delivery. We are committed to having an open, understandable and predictable coverage process that assures access to medical advances for Medicare beneficiaries, while protecting them from services whose effectiveness is unproven.

Medicare has emerged as a leader in the move toward such evidence-based decision making for coverage policy. We rely on state-of-the-art technology assessment and on agencies such as the Agency for Healthcare Research and Quality (AHRQ), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Department of Veterans Affairs (VA), the Department of Defense (DoD) as well as the advice of the medical community and private sector studies. Our own extensive Medicare and Medicaid data contain additional useful information for assessing the effectiveness of all varieties of medical care. The experiences of the Medicare program can benefit the entire health care marketplace.

Medicare continues to develop and implement payment policies that are now being used in the private sector. This is in part due to the sheer numbers of beneficiaries that we serve and the wealth of information available. Examples include prospective payment for inpatient hospitals and the resource-based relative-value system for physician payment. HCFA is now in the process of developing prospective payment systems for other providers such as home health agencies and skilled nursing facilities.

We have chartered a new advisory committee that, when requested, advises HCFA on national coverage decisions. It holds open meetings and provides an opportunity for public participation on coverage issues referred to the committee. The committee is divided into small, clinically focused panels comprised of nationally recognized experts in a broad range of medical, scientific, and professional disciplines, as well as representatives of consumer and industry groups. The committee may review and evaluate medical literature, review technical assessments, and examine data and information on the effectiveness and appropriateness of medical items and services. Based on the evidence, the committee will advise and make recommendations to HCFA regarding coverage.

Health Promotion and Prevention

In 1999, HCFA and the National Cancer Institute continued to work together to increase the awareness nationally of the importance of regularly scheduled mammography screening among women ages 65 and older and to increase the awareness of the new benefit. The campaign theme is "Not Just Once, but for a Lifetime." The goal is to increase the number of Medicare beneficiaries who receive a mammogram to 60 percent. In addition, HCFA and the National Cancer Institute have joined together to promote the importance of regularly scheduled Pap tests for early detection of cervical cancer.

HCFA continued its national campaign to increase the number of Medicare beneficiaries who receive the flu shot under the theme of "Get the flu shot--not the flu!" Special efforts are being aimed to target residents in nursing homes.

HCFA and the Centers for Disease Control and Prevention are working to increase the screening for colorectal cancer within the Medicare beneficiary population. A national campaign, *Screen for Life,* began in March 1999. The campaign encourages Medicare beneficiaries and others to take advantage of screening and promotes the new Medicare coverage of colorectal cancer screening procedures. The campaign produced Medicare-specific posters targeting four audiences (African-American, Caucasian, Hispanic, Asian), media kits, Medicare-specific public service announcements (radio, video), print slicks, and a brochure.

HCFA and the National Diabetes Education Program (NDEP) developed a diabetes promotion and awareness campaign. The campaign was designed to inform Medicare beneficiaries of the expanded Medicare benefits to include both insulin using and non-insulin using beneficiaries that can help them control their diabetes through the use of Home Glucose Monitoring Meters and testing strips. The basis of the campaign, as in the NDEP campaign, was "Control Your Diabetes For Life."

End Stage Renal Disease (ESRD) Initiatives

As the single largest purchaser of ESRD treatment services in the United States, HCFA has a critical responsibility for the quality of care delivered to these patients. Our challenge is to improve the quality and accessibility of the services, while keeping an eye on costs. We have successfully completed another year of data collection and reporting by the ESRD Core Indicator Project. We are building a comprehensive, integrated approach to the quality management process for ESRD on a number of fronts. We are implementing a focused survey process, revising the Conditions for Coverage, developing ESRD clinical performance measures to measure and report the quality of care for dialysis patients, and enhancing the quality improvement projects of the ESRD

networks. Additionally we realize the need for collaboration between HCFA, the ESRD Networks, National Institutes of Health (NIH), United States Renal Data System (USRDS), United Network for Organ Sharing (UNOS), and the Renal Community to develop a data management and analysis initiative which will support quality measurement, as well as better monitoring management of ESRD patients. This initiative includes the development of a larger, more comprehensive database that will be accessible and linked to the HCFA, USRDS, and ESRD Network databases. Users will be able to access financial data (claims and billing), use data (hospitalization), and clinical data (lab and medical records) on all ESRD Medicare beneficiaries. The first stage of the project was completed December 1999.

Diabetes Quality Improvement Project

The Diabetes Quality Improvement Project (DQIP) is a public-private sector quality improvement initiative, initiated and funded by HCFA. The objective of DQIP is to improve health care outcomes for individuals with diabetes. The private sector partners include in the American Diabetes Association, the National Committee on Quality Assurance, the Foundation for Accountability in Healthcare, the American Academy of Family Physicians, the American College of Physicians, and others. Federal partners include the Veteran Health Administration (VHA) and the Centers for Disease Control. DQIP resulted in the first widely accepted comprehensive measure set for chronic disease that includes both process and outcome measures. Wide use of a single measure set allows valid comparisons of care across health care settings with meaningful opportunities to benchmark. Accountability of providers may also be improved by using the same measures. In the year 2000, some or all of DQIP measures will be reported for commercial, Medicaid, and Medicare managed care plans as part of HEDIS, for American Diabetes Association Provider Recognition Program sites, and will be collected by HCFA in all 50 States in the fee-for-service setting. Federal partners, the Indian Health Service, the VHA, and others will also be collecting and reporting the DQIP measures.

Cooperative Cardiovascular Project (CCP)

Improving treatment for heart attack patients has been a focus of HCFA's Health Care Quality Improvement Program since its inception in 1992 with a goal of reducing deaths from heart attacks. HCFA is working toward achieving this goal by improving hospital performance on specific clinical interventions that have been shown to be effective in treating heart attack. In 1996, PROs began to phase in quality improvement activities related to heart attack treatment nationwide. HCFA has continued this effort with increased emphasis on hospital participation, and in 1999, wrote performance-based contracts with PROs, requiring them to achieve State-level improvement on these interventions. All PROs will have initiated these efforts by late FY 2000. Based on the

pilot project, the nationwide effort would be expected to improve 1-year mortality after heart attack by about 1 percentage point. Since approximately 323,000 Medicare beneficiaries are hospitalized for heart attacks per year (data from August 1995 through July 1996), a decrease of one percentage point translates into about 3,000 lives saved.

Organ Donation Activities

HCFA had several activities in FY 1999 designed to promote the Secretary's initiative to increase organ donations. Some examples included:

- HCFA and the Health Resources and Services Administration (HRSA) conducted a workshop of experts from the organ donation community to design a resource guide for training designated requestors to discuss organ donation with families of potential donors.

- HCFA secured the funding for HRSA to conduct a series of four regional "lessons learned" conferences for organ procurement organizations (OPOs) and hospitals to share their successes in implementing the hospital conditions of participation (CoP) for organ, tissue, and eye donation. The conferences, which are being co-sponsored by HCFA and HRSA, will take place in the four HCFA Regional Consortia from January through March 2000.

- HCFA released a final, comprehensive set of 54 Questions and Answers about the CoPs which has been posted on HCFA's Web site and distributed to the organ donation community.

- HCFA signed a contract with the Harvard School of Public Health for further study of a model for estimating donor potential in hospitals. HCFA is analyzing various methodologies for estimating donor potential that could be used as alternatives to HCFA's current, population-based performance standards for OPOs.

Nursing Home Initiative

The President's nursing home initiative provides enhanced protections for nursing home residents. It targets needed improvements in nursing home quality through a number of enhancements to the survey and monitoring process. Changes to the survey process include more emphasis of care areas such as nutrition, hydration, pressure sores, unnecessary drugs and better interventions to prevent neglect and abuse in nursing homes. The initiative also calls for more frequent inspections of facilities that repeatedly violate standards, as well as staggered inspections on weekends and evenings to ensure

uniformity in the quality of care. In addition, HCFA began a campaign in 1999 to raise awareness about detecting and reporting neglect and abuse in nursing homes under a theme of "Sometimes Abuse Is Not So Obvious." Certified Nursing Assistants are being targeted to increase their awareness of "Nutrition Care Alerts" and the action steps they can take to correct the situation."

Hospital Quality Oversight

HCFA is improving the oversight and quality of care in hospitals participating in the Medicare and Medicaid programs. Our initiative is designed to improve the accountability of accrediting organizations, the meaningfulness of survey information, and the systems for data collection and information sharing. Accomplishing this will include collaborating with the major accrediting agencies such as the Joint Commission of Accreditation of Healthcare Organizations and the American Osteopathic Association as well as with state agencies. This in response to the recommendations of the Office of the Inspector General's Draft Report, "The External Review of Hospital Quality -- A Call for Greater Accountability."

The Quality Improvement System for Managed Care (QISMC)

QISMC is a set of standards and guidelines for managed care organizations that address those areas of their operation that are closely related to quality measurement and improvement as well as the delivery of health care and enrollee services. Among other things, QISMC calls for managed care organizations to report on standard quality measures and to undertake performance improvement projects.

For Medicare, QISMC is equivalent to a program manual. Medicare+Choice organizations have been required to comply with it since January 1, 1999. For Medicaid, QISMC serves as a model for States to use in developing requirements for Medicaid managed care organizations to achieve compliance with the quality related provisions of the Balanced Budget Act of 1997.

Beneficiary Rights & Protections

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry issued a paper on the Consumer Bill of Rights and Responsibilities (CBRR) in November 1997. This document calls for a national effort to improve and sustain the quality of health care in the United States. We are working to ensure that health care programs are providing the full range of rights and protections to the recipients and beneficiaries of such programs. Two implemented regulations establish requirements for organizations participating in Medicare and strengthen protections for Medicaid beneficiaries enrolled in managed care arrangements.

Other protections in the CBRR include the right of redress through appeals, grievances, and complaints. For example, a Grievance Procedures and Appeals Data Collection Workgroup identified areas for quality improvements and new dispute resolution processes and procedures.

HCFA published the Patients' Rights Condition of Participation (CoP) for hospitals, which promotes patient health and safety by protecting several key rights. The CoP requires that the patient be notified of his rights, and supports patient involvement in care and decision making. While the new CoP also covers fundamental rights, such as patient privacy, patient safety, and confidentiality of patient records, the most notable and perhaps controversial is the right to be free from restraints and seclusion.

Educating Beneficiaries for Value Based Decision Making

Defining Beneficiary Needs

The Medicare Current Beneficiary Survey (MCBS) helps in monitoring and evaluating the health care needs of Medicare beneficiaries. It also helps us ensure that programs and services respond to the health care needs of our beneficiaries in a number of ways. It is the only comprehensive source of information on the health, health care, socioeconomic, and demographic and other characteristics of aged, disabled, and institutional Medicare beneficiaries. It directly involves beneficiaries in defining their health care needs by interviewing a large representative sample of them about their health status and physical functioning, access to care, and satisfaction with the Medicare services they use. MCBS aids in HCFA's educational and outreach initiatives by collecting information to determine which methods are best suited to reaching specific subgroups of the Medicare population, and what the communication preferences are for the general Medicare population and several specific subgroups. A section of questions specific to beneficiary information initiatives was added to the MCBS to gather data on "Medicare & You 2000."

HCFA is conducting market research and has completed the inventory work of documenting what is known about beneficiary information needs and communication preferences for the general Medicare population and several specific subgroups. The majority of focus groups have been completed for these same populations and the MCBS data were gathered during the spring of the year. Draft reports of results from these activities are becoming available and we have begun to distribute them to the HCFA staff. We have also received reports of findings from work with providers and other partners.

Beneficiary Outreach

Through the National Medicare Education Program, HCFA has continued to help beneficiaries make informed choices about their health care. The 124 member Alliance Network, formed in 1998 achieved new partnerships in 1999. Through the Alliance HCFA built a formal relationship with libraries across the country to make Medicare a focus for their information and assistance efforts.

HCFA partnered with Employer Trade Groups in 1999 to help them educate their retirees. This resulted in employers and other providers of retiree health benefits better crafting their benefits to coordinate well with Medicare+Choice. Through "Medicare & You" projects, HCFA has also created a national focus on caregivers and their families. This link highlights the direct aid caregivers provide our beneficiaries as well as furthering our ability to educate people prior to their achieving initial eligibility. Through a USDA partnership, HCFA took this link one step further connecting kids, seniors and the Internet.

Additionally, HCFA cultivated new partnerships at the local level that are integral in the implementation of the REACH Campaign. The REACH Campaign consists of 3,400 locally oriented activities for beneficiaries, including health fairs, public meetings, and efforts to reach beneficiaries through the local media, including public service announcements, paid advertising, and radio call-in programs.

HCFA's Web Sites

HCFA's data bases are the largest and most complete source of health care information in the United States. In 1996, HCFA unveiled a new, expanded Internet website, http://www.hcfa.gov, that offers data, statistics, publications (including our annual financial report), guidelines on detecting fraud, and other material for our beneficiaries, contractors, and the general public. Although many beneficiaries do not have access to the Internet, beneficiary and consumer advocates, insurance counselors, and public entities who are the most frequent sources of beneficiary advice and counseling do possess this technology.

The www.medicare.gov website has been operational since early 1998 and in November 1999, received the first place Gold Award for best government health care web site, and the second place Silver Award for best site for seniors/boomers in the first annual Healthcare World awards competition. The web site is one of the keystones of HCFA's multifaceted beneficiary-centered public information program that has been designed to improve the quality of health care. Its target audience includes Medicare beneficiaries, caregivers, and advocacy groups. The site which started out with one small database called "Medicare Compare", which displayed comparative health plan information, has

evolved into an elaborate wealth of information which is supported by a variety of interactive databases. Similarly, the general health plan information which was the seed for Medicare Compare has burgeoned into an array of information that has been customized to suite target audiences and the types of information they require or may request.

In just a little longer than a year several enhancements have been added to the site. The "Health Plan Employer Data & Information Set (HEDIS)" and the "Consumer Assessment of Health Plans Study (CAHPS)" display health plan quality satisfaction information. "Nursing Home Compare" arrays the survey results of nursing homes for comparison by name and location. The "Important Contacts" database provides the phone number of any Medicare related agency in their state. "Medigap Compare", a database containing insurance information searchable by state and zip code, and the Outreach Calendar, a database containing the locations of health fairs and other information/ education meetings and events, also searchable by state, is in the offing. To compliment this array of information, Spanish, Chinese, Large Print and various other language and visual enhancements have been added to the site.

Annual Publications

During 1999, "Medicare & You 2000" was mailed to 33 million beneficiary households nationwide. This handbook also is available in a variety of alternative formats, including Spanish, audio tape, large print and braille.

HCFA and the National Association of Insurance Commissioners (NAIC) published the "1999 Guide to Health Insurance for People with Medicare" which provides detailed information on purchasing and using Medigap and other types of private health insurance. This Guide is available in English, Spanish, large print, braille, and audio tape.

Many other publications were revised or introduced in 1999: including; "*Do You Need Help to Pay Health Care Costs?*"; "*Does Your Doctor or Supplier Accept Assignment?*"; "*Guide to Choosing a Nursing Home*"; "*Medicare Appeals and Grievances*"; "*Medicare Coverage of Kidney Dialysis and Transplant Services*"; "*Medicare Home Health*"; "*Medicare Hospice Benefits*"; "*Medicare Patient Rights*"; and "*Medicare Private Fee-for-Service Plans.*"

Medicare + Choice

The Medicare+Choice program's goal is to ensure beneficiaries will be provided with quality services and information. HCFA developed comprehensive directions for

organizations regarding the new Medicare+Choice eligibility, election, and enrollment procedures.

We undertook nationwide campaigns to educate providers, plans and groups on the new eligibility and enrollment provisions. This Alliance Network, which has grown to 124 partnerships in 1999, has greatly improved the dissemination of comprehensive information. Via the Internet we have been able to ensure that plans and advocacy groups receive new policies promptly and increase beneficiaries' program knowledge and their awareness and utilization of rights and protections.

The National Medicare Education Program was implemented in 1998, using several channels to reach beneficiaries with accurate, consistent information on their health plan options, the basic Medicare program, beneficiary rights and protections, as well as issues of local concern such as plan terminations. The strategy included direct mail of the "Medicare & You 2000" handbook to all Medicare beneficiaries, a national toll free assistance line 1-800-MEDICARE (1-800-633-4227), and the medicare.gov beneficiary website. The Regional Education About Choices in Health (REACH) Campaign, a nationally coordinated outreach campaign consisting of close to 2,000 localized activities was carried out by HCFA's Regional Offices. More than 1,000 outreach activities were held nationwide in the fall of 1999 as part of the REACH campaign to increase awareness of Medicare+Choice, and Medicare issues.

We improved customer service to beneficiaries through creation of an additional disenrollment process, which is to be tested on the Medicare+Choice help line. In addition, information gathered form these disenrollments will provide insight into reasons for beneficiary disenrollment, allowing for constant improvement in the services that beneficiaries receive.

Medicare Consumer Assessment of Health Plans Study (CAHPS)

Medicare CAHPS is an initiative to collect and report information on beneficiaries' experiences in receiving care. An annual nationwide survey is conducted of Medicare beneficiaries enrolled in managed care plans about their satisfaction with plan performance. The primary purpose of this survey is to provide information to Medicare beneficiaries to help them make more informed choices among health plans.

In addition to the managed care survey, two other CAHPS initiatives are currently under active development. The Medicare CAHPS Disenrollment Survey will collect information from beneficiaries who have recently left a Medicare managed care plan about their experiences while plan members, and their reasons for leaving that plan. HCFA will begin collecting data nationally in 2000 and first report this information in 2001. The other initiative underway is the development of a data collection instrument

for obtaining information on beneficiaries' experiences and satisfaction with the Medicare fee-for-service (FFS) program. A pilot of the CAHPS-FFS survey was field-tested in five states in 1998. National implementation of the Medicare CAHPS-FFS survey is scheduled for fall 2000, with information from this survey being made available to beneficiaries in fall 2001.

Activities to Assist in Value-Based Purchasing

In 1996, we worked with the National Committee for Quality Assurance (NCQA) to adopt a system of quality measures called HEDIS, the Health Plan Employer Data and Information Set. HEDIS created measures that could be adapted to Medicare and Medicaid and resulted in HEDIS 3.0. In 1998 and 1999, we required more than 250 Medicare managed care risk and cost contractors to report measures from HEDIS to the NCQA. These measures included effectiveness of care, use of services, access to care and other areas where we thought it important for HCFA as the largest purchaser of health care to have a better understanding of the performance of Medicare managed care plans.

We also mandated audits of the data submissions in order to ensure it accuracy and validity. We are currently analyzing both the HEDIS data submitted by the plans, and the audit results as we determined the best ways of using HEDIS in improving quality of care and in providing consumers with information in choosing among plans. HCFA intends to combine HEDIS measures with other information that HCFA collects about health plans, such as beneficiary satisfaction, physician reimbursement arrangements, and disenrollment. For Medicaid, the States have the option of using those HEDIS measures that are most appropriate for their populations. HCFA is also exploring the feasibility of calculating selected effectiveness of care measures for its fee-for-service population.

Other Value-Based Initiatives

HCFA is currently conducting several other major initiatives and demonstrations that can help make HCFA a more prudent purchaser of services by incorporating innovative payment approaches while fostering the provision of quality health care. Two examples are:

- The DME Competitive Bidding Demonstration uses market competition to help beneficiaries and the Medicare program obtain quality DME products in certain categories at more reasonable rates. As in the private sector, the dynamics of the marketplace are expected to provide incentives for suppliers to offer quality DME items and services at competitive prices, resulting in savings for beneficiaries and the Medicare program. The first site for these demonstrations began in Polk County,

Florida, on October 1, 1999. The process has been successful in protecting quality and access for beneficiaries while reducing the cost to beneficiaries and Medicare by an average of 17 percent compared to otherwise required Medicare rates for those products. A second demonstration at another site is being planned for 2000.

- Under the Competitive Pricing Demonstration, payments to managed care organizations in specified areas will be determined by a competitive pricing methodology. Two sites, Phoenix and Kansas City, have been selected to participate initially in this demonstration, but the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 delayed implementation of the demonstration until January 1, 2002, at the earliest. The competitive pricing Advisory Committee, comprised of health policy experts charged with making recommendations on the demonstration design and selecting demonstration sites, will prepare a report to Congress on recommendations for potential demonstration changes.

ELECTRONIC DATA PROCESSING

HCFA is the largest consumer and maintainer of health data in the world. There are a number of major initiatives underway to move HCFA into the twenty-first century. The most critical of these is planning for the millennium.

Transitioning to the Next Millennium

The overriding goal of HCFA for the Year 2000 transition was to preserve the agency's ability to serve its customers. By safeguarding its critical business functions, HCFA ensured its ability to carry out its mission, which assured health care security to the beneficiaries of Medicare and Medicaid and other HCFA-administered programs.

All of HCFA's internal systems were renovated, fully tested, certified compliant, and implemented by the government-wide Year 2000 goal of March 31, 1999. This included the systems that manage the eligibility, enrollment, and premium information of Medicare beneficiaries, and those that make payments to managed care organizations that contract with HCFA. In addition, all of the external claims processing systems, those operated by private insurance contractors that process Medicare fee-for service claims and pay bills, were fully tested, including future-date tested, and certified as compliant. All of these systems were processing and paying Medicare claims prior to January 1, 2000. HCFA's independent verification and validation (IV&V) contractor, with oversight from the Department of Health and Human Services' Inspector General, verified the readiness of these external systems.

HCFA developed and implemented a process for performing Year 2000 renovations, certification testing, and validation which ensured HCFA's high quality work and that

HCFA's systems remained Year 2000-ready. HCFA exceeded the GAO's recommendations in the design and performance of the testing regimen. These activities included: Unit Testing, Integration Testing, End-to-End Testing as well as employing validation tools to certify the quality of code renovation. In November 1999, HCFA completed re-certification testing to re-verify that HCFA's systems are working and that software changes made during 1999 to fulfill legislative mandates and improve program operations did not affect previously achieved Year 2000 compliance. These extensive tests provided further assurance that all of HCFA's external systems and internal systems that underwent any significant change would function in the new millennium.

As part of HCFA's overall preparedness strategy, HCFA implemented a command and control structure with staff assigned to proactively assess the status of all of the business systems during the millennium transition. This staff guided HCFA's reaction and management of any unforeseen Year 2000 events. The staff tracked the status of HCFA's health care programs; organized HCFA's decision-making processes for identifying and resolving problems so as to better recognize trigger events; and reported on the status of all of HCFA's programs, including mission-critical system operations and business continuity functions. They were prepared to request that Emergency Response Teams implement contingency plans if necessary.

Contingency planning

While HCFA believed the risk of Year 2000 failures of its systems to be low, HCFA worked diligently to prepare for any potential failures. HCFA developed business continuity and contingency plans for its critical business processes, worked with State agencies, managed care organizations, Medicare intermediaries and carriers, and health care providers to ensure that Medicare and Medicaid beneficiaries' access to quality health care would not be affected by the Year 2000 transition.

The overall plan consisted of (1) risk mitigation plans designed to eliminate, or at least mitigate, anticipated risks and (2) contingency plans that specify actions HCFA will take should a system or critical process fail. In general, HCFA's contingency plans specified alternate means for conducting business pending completion of system repairs and restoration of normal operations. The strategies reflected in-depth business impact analysis, definitions of minimum acceptable outputs for critical business processes, and analysis of alternative approaches to protect logical groups of business functions.

HCFA developed more than 50 contingency plans, each with a designated Emergency Response Team responsible for executing the plan. Prior to January 1, these teams tested their plans by implementing them in a simulated environment. Claims processing contractors put contingency plans in place that were carefully reviewed at each

contractor's site by HCFA staff. The GAO attended several of these reviews. HCFA continued to assist its partners, including managed care organizations, State Medicaid plans, and the health care provider community at large, develop and validate their own contingency plans until they could guarantee their ability to function in the new millennium.

HCFA determined the greatest risk to the program to be the uncertainties in the readiness of Medicare providers. While HCFA suspected that larger organizations were in better shape, the readiness of individual providers in rural and inner city institutions was of concern. Accordingly, HCFA's biggest risk mitigation effort was an unprecedented outreach campaign to health care providers and their trade associations to raise awareness of the need to make Year 2000 systems changes. HCFA strongly encouraged health care providers to generate and submit future-dated test claims to HCFA's contractors. Special emphasis was placed on reaching out to the larger billing companies and clearinghouses that many providers use to submit Medicare claims. HCFA encouraged these companies to ensure through testing that their remediation efforts were successful.

HCFA required all Medicare MCOs to certify that their systems would perform in the new millennium. The Medicare MCOs were required to provide HCFA copies of their contingency plans for review. HCFA determined that approximately two-thirds of the initial contingency plans submitted needed improvement. Review of contingency plans initially submitted by national chains indicated that 50 percent were reasonable or in need of minor improvement, while the other 50 percent needed major revisions. HCFA endeavored to assist those MCOs with less-than-adequate plans in revising and strengthening their plans in a variety of ways. Technical assistance workshops in Los Angeles, Denver, and Atlanta were held to provide guidance on contingency planning principles, as well as to respond to particular concerns regarding the MCOs' contingency plans. The result was that all of the Medicare MCOs' contingency plans were adequate.

HCFA worked closely with the nation's Governors and State Medicaid Directors to ensure that state Medicaid agencies were ready for the Year 2000. HCFA hired expert consultants who, through site visits, assessed states' progress against each state's Year 2000 Medicaid readiness goals and standards. We provided technical assistance on compliance protocols, testing, contingency planning strategies, and best practice information. HCFA conducted site visits to every state and the District of Columbia continuing to assist those who had particular difficulties, including providing technical support in developing and evaluating their contingency plans where needed.

Standardizing Systems

To become a more effective administrator of Medicare, we have been working to consolidate the Medicare payment systems into three standard systems, one for fiscal

intermediaries, one for carriers and one for durable medical equipment carriers. This will simplify operations; enable HCFA to implement more effective change control processes, and ensure that the highest priority changes are made first. Consolidation of the durable medical equipment system was completed. However, it was necessary to delay some of the fiscal intermediary and carrier transitions to the selected system in order to concentrate HCFA's resources on ensuring Medicare contractors achieved Y2K compliance. While transitions were delayed, systems requirements for the integrated accounting systems for the contractors were developed. These systems changes will be included in the queue for implementation once Y2K compliancy efforts are concluded.

We are working with the States and the health care industry to implement the BBA provision requiring all States to submit claims data (including encounter data) through the Medicaid Statistical Information System (MSIS) beginning January 1, 1999. Currently more than 30 States participate on a voluntary basis. We have initiated a consultation process with the States to develop an implementation plan as well as enhanced methods for the receipt, transmission, and reporting of Medicaid data. We have also solicited input and assistance from other users, including the research community. Total participation by all States in MSIS will for the first time provide for a unique national standardized Medicaid database, reflecting an annual volume of approximately 1.5 billion records of Medicaid statistical information.

Information Systems Security

HCFA's business needs and information technology capabilities are changing the way HCFA is doing business. We have an ever expanding set of partners and customers; we want to conduct business more quickly using direct telecommunications; we have a presence on the Internet and wish to leverage its capabilities in greater ways. This environment presents new opportunities as well as new information systems security risks that HCFA must manage. We recognize that, with HCFA's missions increasingly dependent on information, a strong systems security infrastructure is essential to HCFA's success. A HCFA security initiative has been outlined and encompasses all aspects of HCFA information systems security: policy, administration, training, engineering, and oversight. The initiative establishes the structure for an evolving program to establish a technical and an administrative framework.

Information Technology Investment Process

HCFA's accounting system, FACs and the Integrated General ledger Accounting System (IGLAS) are the first financial systems to be initiated under the IT Investment Process. In accordance with the Clinger-Cohen Act of 1996, HCFA developed a formal IT Investment Process. This process focuses on the selection, control, and evaluation of all

IT projects, ensuring that they are implemented at acceptable costs, within reasonable time frames, and are contributing to tangible, observable improvements in mission performance. In conjunction with the IT Investment Process, HCFA has established a Technical Review Process for major IT investments. This process will ensure that IT projects are developed consistent with the Agency's IT architecture standards (business, applications, infrastructure, information, security, and the governing policies and procedures); promote effective workload management (enterprise scheduling and resource planning) for internal, external, and contractor resources required to deploy the IT application and/or system; and provide project owners with a clearly-defined process and a central focal point for involving IT professionals in the development of the project technical solutions.

Provider Outreach Campaign

HCFA is conducting an unprecedented professional and provider outreach campaign through the Office of Professional Relations (OPR) within the Center for Health Plan and Providers (CHPP). The professional relations function at HCFA supports a number of activities viewed as essential to efficient, effective provider communications and transitions that ultimately benefit HCFA beneficiaries. OPR's outreach activities include letters from the Administrator to doctors, hospitals, labs, and other health care providers; and teleconference calls and meetings with physicians in all 50 states. In addition, OPR is currently developing an innovative method via the Internet to exchange information with physicians and providers.

Financial Accomplishments and Statement Highlights

One of the major benefits of the CFO Act has been to highlight the importance of accurate financial reporting and reliable internal controls. The CFO audit has helped us identify areas that need attention to ensure that we are presenting an accurate financial picture of HCFA. Since the first CFO audit of HCFA's financial statements, our goals have been to achieve an unqualified opinion or "clean opinion" from the auditors indicating that HCFA's financial statements are fairly presented in all material respects and to improve our internal controls and systems. Over the past several years we have made tremendous strides in these endeavors.

CFO Audit

Introduction

In FY 1996, the auditors were unable to validate the reliability of supporting documentation presented by HCFA and our Medicare contractors and issued a disclaimer of audit opinion. The auditors identified major concerns in the areas of Medicare accounts payable, Supplementary Medical Insurance (SMI) revenue, accounts receivable, and cost report settlements. Our efforts to improve financial controls over these areas were successful and, by FY 1998, only one issue remained that prevented HCFA from receiving a clean audit opinion. This issue was the accuracy and supportability of our accounts receivable balances, most of which are maintained on our behalf by our fiscal intermediaries and carriers. These organizations, commonly referred to as Medicare contractors, have contracted with HCFA to administer the day-to-day operations of the Medicare program. They pay claims, audit provider cost reports, establish and collect overpayments. Because the systems used by the Medicare contractors have not always produced data which was adequately supported, our auditors have had difficulty validating their accounts receivable balances.

Accounts Receivable

To obtain a "clean opinion" we recognized that our financial statements had to properly reflect accounts receivable at their true economic value based on provisions provided within the Office of Management and Budget Circular A-129, *Managing Federal Credit Programs.* Medicare accounts receivable are primarily comprised of provider and beneficiary overpayments, and Medicare Secondary Payer (MSP) receivables which are comprised of paid claims in which it was subsequently determined that Medicare should have been the secondary rather than the primary payer.

Revised Reporting Policy

During FY 1999, we performed extensive analysis of our delinquent debt, specifically related to the likelihood of collecting it and the need for writing it off if we determined it was uncollectible. As a result, HCFA implemented a number of policy changes in the reporting of delinquent debts in order to properly reflect accounts receivable balances at their true economic value. Our revised procedures provide for uncollectible delinquent debt to be written-off/closed without any further collection activity or reclassified as Currently Not Reportable/Collectible. The Currently Not Reportable/Collectible category of debt will continue to be referred for collection and litigation, but will not be reported on the financial statements, since our analysis showed there is minimal chance of collecting these debts. This allows delinquent debt to be worked until the end of its statutory collection life cycle. HCFA has adopted this policy as part of our efforts to improve financial reporting and established standards to manage and report delinquent debt.

Ensuring MSP debts are recorded at an appropriate value was our second challenge in this area. HCFA reviewed its policy for the recognition of MSP group health plan (GHP)-based accounts receivable because it is the largest single type of MSP debt. We concluded that all MSP accounts receivable will continue to be recorded on the financial statements as of the date the MSP recovery demand letter is issued. However, the MSP accounts receivable ending balance will reflect an adjustment for expected reductions to GHP accounts receivable for situations where HCFA receives valid documented defenses to its recovery demands. Data obtained from Medicare contractors indicated that valid documented defenses are received from debtors within 240 days of the demand date and results in the reduction of the total GHP demanded amount by approximately 30 percent. Thus, the MSP accounts receivable ending balance that is less than 241 days old has been reduced by 30 percent in order to reflect MSP GHP accounts receivable balances at their true net realizable amount.

Adjustments to Previous Reported Receivables

In addition to issuing revised policies, we hired independent certified public accountants (consultants) to assist us in validating the accuracy and completeness of our accounts receivable balances. The consultants reviewed approximately 81 percent of the outstanding accounts receivable balance reflected in last year's financial statements. Moreover, OIG performed similar work to validate accounts receivable balances at HCFA central and regional offices.

These efforts resulted in significant adjustments and write-offs to accounts receivable. This year's financial statements reflect adjustments of about $1.3 billion (principal and interest) resulting from the validation efforts performed by the OIG and our consultants, as well as revised policies and supplemental guidance we provided to the Medicare contractors.

An additional $2.7 billion of accounts receivable (principal and interest) were not included on our financial statements as a result of implementing our new delinquent debt reporting policy. This is the amount of delinquent debt that was classified as "Currently Not Reportable/Collectible." The majority of this amount, about $2.1 billion, represents MSP debt that had accumulated over the past seven years and represents less than 1/6 of one percent of total Medicare payments during that time. An additional $300 million in accounts receivable balances were written off where collection action was terminated. The allowance for uncollectible accounts receivable determined this year was calculated based on our collection activity for the most current fiscal year, taking into consideration the significant amount of accounts receivable balances that were removed from the financial statements.

Debt Collection Improvement Act (DCIA)

Under the DCIA, Federal agencies are required to refer debts to the Treasury Offset Program (TOP) and transfer debts to a Designated Debt Collection Center (DCC) for cross-servicing once they have become 180 days delinquent. Debts referred to the TOP are housed in the National Interactive Database and matched to federal payments for potential offset. HCFA is required to discontinue collection activity on debts transferred to a DCC for cross servicing. The DCC performs a variety of collection activities including sending additional demand letters, skiptracing, referring debts to the TOP, referring debts to private collection agencies, negotiating repayment agreements, and eventually referring some debts to the Department of Justice for litigation if necessary. HCFA has actively embraced DCIA and begun the task of validating and referring its delinquent debts to a DCC. The Department of Health and Human Services' Program Support Center (PSC) will serve as the DCC for all MSP debts and a small portion of Non-MSP debts. The majority of Non-MSP debts will be transferred to TOP, via the PSC, for cross-servicing. Most of these debts will be transferred to the DCC in FY 2000 with the remaining debts transferred during FY 2001.

During FY 1999, HCFA implemented a process for referral of all MSP debts more than 180 days delinquent for cross-servicing by the PSC. HCFA is working with Blue Cross and Blue Shield of Georgia as a test site for this effort. After reviewing the results of this effort, we will establish National priorities for the referral of MSP debt based on the age and the dollar value of the debt.

HCFA expects the cross-servicing referrals to be developed manually or with existing systems until the Recovery Management and Accounting System (ReMAS) implementation in 2001. Despite the significant volume of delinquent MSP debt, HCFA expects steady progress towards its goal of 100 percent referral by FY 2002 of MSP debt that is more than 180 days delinquent. We continue to refer debt in accordance with the DCIA and in FY 1999, we collected over $3 million of delinquent Medicare debts.

Financial Management & Reporting

We continued to make improvements and develop strategies addressing other areas of financial management including budget execution, guidance to Medicare contractors, Medicare contractor oversight, financial reporting, and Medicare secondary payer initiatives. In an era of limited resources and heightened management accountability, it is imperative that financial management and reporting receive priority attention.

Budget Execution

We have improved our budget execution for the Program Management Appropriation. We established the Financial Management Investment Board (FMIB) to allocate agency resources in support of agency priorities. In addition, we established lapse targets for each Program Management allotment, and managed funds aggressively to meet those targets. This ensured available funds were identified timely and allocated to fund agency priorities.

Guidance to Medicare Contractors

Medicare contractors provide much of the financial data HCFA uses to manage the Medicare program. The importance of ensuring that they are effectively managing resources and reporting accurate financial data cannot be emphasized enough. Therefore, HCFA continued its efforts to hold Medicare contractors accountable for improved financial management.

We revised financial reporting policies and procedures relating to the financial reports submitted to HCFA by the Medicare contractors. We made it a policy to issue clarifying guidance to all Medicare contractors when individual contractors raised questions. Our goal is to continue to improve the consistency of information provided by the Medicare contractors.

Training conferences were held for all the Medicare contractors and HCFA regional offices, with participation from the OIG, the United States General Accounting Office, and contract Certified Public Accountant (CPA) firms. We presented our revised policies and procedures for financial reporting and also emphasized the importance of documenting internal controls. With assurances that data is validated and complete, we have greater confidence in the accuracy and reliability of the financial information reported.

For the first time, fiscal intermediaries assisted HCFA in the development of review protocols for provider audits that will be performed during FY 2000. These protocols concentrated on areas of Medicare vulnerability, such as auditing home health agencies. Additional audit programs and uniform desk programs were developed for hospitals and skilled nursing facilities (SNFs).

Medicare Contractor Oversight

Two separate task orders were issued regarding Medicare contractors' internal controls. The first task order covered a review of the supporting documentation maintained by Medicare contractors to justify their internal control Certification Statements they submit annually to HCFA and will also test specific financial management internal controls. The review will be performed at 25 Medicare contractors during FY 2000. The second task order is to develop a financial management internal control manual that will be used in the future to systematically review all Medicare contractors financial management internal controls and subsequent corrective actions.

In FY 1999, financial management was a mandatory area included in Regional Office contractor performance evaluation reviews of all Medicare contractors using standard protocols for accounts receivable and accounts payable. The Medicare contractors will be required to correct all identified deficiencies in a timely manner.

HCFA also conducted a National conference to identify specific areas at the Medicare contractors where debt collection activity is lacking. We will focus our future reviews of the Medicare contractor collection activities, accordingly.

Our Audit Quality Review Program (AQRP) contracts proved successful. The AQRP reviews increased oversight of the procedures used by Medicare contractors to perform audits of provider cost reports.

Financial Reporting

We have improved our financial statement reporting process within HCFA Central Office. All financial data, including data provided by the Department of Treasury and other Federal Agencies, is now included in HCFA's general ledger. The process of preparing the financial statements from our general ledger has also been automated. These two accomplishments corrected previous deficiencies identified by our auditors. We also produced interim financial statements for the first time and successfully submitted our financial statements on the new automated financial statement system implemented by the Department of Health and Human Services.

We have also complied with the November 1999 reporting requirement of the Federal Agencies Centralized Trial Balance System (FACTS) II and the February 2000 reporting requirements of FACTS I.

We improved the operation of the accounting system by programming and successfully implementing 74 enhancements. These changes ensured that we met new program and Treasury requirements, as well as improved our administrative and accounting operations.

Medicare Secondary Payer

Our efforts in the MSP area have saved the Medicare trust funds approximately $3.3 billion dollars, an increase of $100 million over last year. All five MSP categories showed an increase. These include working aged, workers compensation cases, end stage renal disease (ESRD) cases, no-fault insurance cases (such as auto insurance), and liability cases. We continue to work with the U.S. Department of Justice to include repayment to the Medicare trust funds when a product liability suit is brought against a manufacturer. During FY 1999, HCFA made progress toward the recovery of funds from litigation, including various products such as the Bone Screw, Heart Valves and Breast Implants.

Other Initiatives

In FY 1999, HCFA worked with the Home Health Industry to develop a strategy for dealing with the large amounts owed HCFA as a result of BBA implementation. We successfully met our objective to ensure repayment to the Medicare trust funds, while allowing home health agencies (HHAs) to continue providing services to Medicare beneficiaries.

For several years, the backlog of unsettled managed care cost reports has increased. In FY 1999, we reversed this trend and reduced the backlog of unsettled cost reports by approximately 63 percent. Disallowances resulting from these settlements amounted to $70.2 million. This represents an increase of $39.7 million or 130 percent over FY 1998. We anticipate that the backlog will be completely eliminated by the close of FY 2000. Utilizing the expertise of CPA firms will help ensure that we will not regress in this area in the future.

We also made important accomplishments in our administrative payment areas as well. We continued to pay all of our administrative payments on time in accordance with the Prompt Payment Act. Over 98 percent of our vendor payments are paid electronically and 100 percent of travel and grant payments were paid electronically.

HCFA Integrated General Ledger Accounting System

We recognize that HCFA's financial management environment is large and complex. The HCFA Integrated General Ledger Accounting System (HIGLAS) project will mesh a proposed integrated general ledger accounting system (IGLAS), that incorporates the financial data of every Medicare contractor, into HCFA's internal accounting system, the Financial Accounting and Control System (FACS). IGLAS will define core financial needs and associated system operations for accounting and financial data related to the Medicare contractors. The redesign of FACS will be coordinated with the IGLAS project.

Work on these two efforts will be conducted in tandem because the ultimate goal of both is to produce and maintain a HCFA consolidated general ledger that issues supportable financial

statements and provides meaningful financial data. While the evaluation and selection of the HIGLAS software will fully consider the requirements of both IGLAS and FACS, the implementation track of the two systems will be tailored to HCFA's priorities and needs. The IGLAS component will be, by far, the most complicated of the two endeavors because it involves so many disparate entities (i.e., the Medicare contractors).

IGLAS will enhance payment management functions by maintaining provider information that includes all data necessary to support obligations, accounts payables, and disbursements. IGLAS will also strengthen the management of accounts receivables since it will record detailed information for Medicare claims overpayments based upon billing sources, event and/or time period, and type of claims overpayment. IGLAS will interface and retrieve information from the three selected standard claims processing systems, the Fiscal Intermediary Shared System (FISS), the Medicare Carrier System (MCS), and the Viable Information Processing System (VIPS) for durable medical equipment regional carriers (DMERCs).

During FY 1999, the claims processing system used by Fiscal Intermediaries was evaluated for compliance with the Joint Financial Management Improvement Program and the Federal Financial Management Improvement Act of 1996 (FFMIA). The analysis showed that it would not be cost effective to bring this system into compliance. Our resultant strategy involves acquiring commercial off the shelf (COTS) software and linking it to our selected claims processing systems.

FACS directly supports the generation of the agency's financial statements and other required reports. Although FACS substantially meets the FFMIA standards, the current systems architecture for FACS does not allow for cost-effective implementation of all its requirements or for value-added requirements such as budget formulation, electronic data interchange, and electronic document workflow to increase administrative efficiencies. The system also uses the Integrated Data Management System, which does not meet the new HCFA information Technology Target Architecture. Since FACS is the only system that operates on this platform, its costs and support are additional agency expenses.

Accounts Receivable Systems

Concurrent with IGLAS, HCFA is developing two accounts receivable systems. The systems requirements for both of the account receivable systems have almost been completed. The Medicare Accounts Receivable System (MARS), will collect specific financial data relative to HCFA's accounts receivable being reported at the central office, regional office and contractor level. In combination with IGLAS, MARS will facilitate the preparation of the Report of Public Debt (Schedule 9), which is sent to the Department of Treasury on a quarterly basis.

The Recovery Management and Accounting System, or ReMAS, will accumulate and report information on MSP debt. ReMAS will replace numerous systems currently in use by Medicare contractors and retain the services of a specialty contractor to manage the bulk of the MSP debt from group health plans. The reporting relationship of ReMAS and MARS will be fully integrated with IGLAS, which is still under development.

Statement Highlights

Consolidated Balance Sheet

The Consolidated Balance Sheet presents amounts of future economic benefits owned or managed by HCFA (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). HCFA's Consolidated Balance Sheet shows $211.6 billion in assets. The bulk of these assets are in the Trust Fund Investments of $180.3 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." The next largest asset is the fund balance of $17.8 billion, most of which is for Medicaid and the State Children's Health Insurance Program (SCHIP). Liabilities of $38.6 billion consist primarily of the Entitlement Benefits Due and Payable of $35.3 billion. HCFA's net position totals $172.9 billion and reflects the cumulative results of the Medicare Trust Fund investments and the unexpended balance for SCHIP.

Consolidated Statement of Net Cost

The Consolidated Statement of Net Cost shows the cost of the major components of HCFA's operations, less any earned revenues. The three major programs that HCFA administers are Medicare, Medicaid, and SCHIP.

Total Benefit Payments were $310.4 billion for FY 1999. This amount includes estimated improper Medicare payments of $9.1 to $17.9 billion based on an audit by the Office of the Inspector General. Administrative Expenses were $2.9 billion, less than 1 percent of total Program/Activity Costs of $315.8 billion.

The net cost of the Medicare program including benefit payments, Peer Review Organizations, Medicare Integrity Program spending, and administrative costs, was $254.3 billion. HI Program/Activity Costs of $133.6 billion were offset by $1.4 billion in premiums. SMI Program/Activity Costs of $142.3 billion include $62.5 billion from the Payments to the Health Care Trust Fund and were offset by premiums of $20.2 billion.

Medicaid expenses were $109 billion. This represents expenses incurred by the States and Territories that were reimbursed by HCFA during the fiscal year, plus accrued payables. SCHIP expenses of $527 million are shown in the "Other column." Activity during the year related primarily to approval of State plans.

Consolidated Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. The line, Appropriations Used, represents the Medicaid appropriations used of $108.9 billion and $69.8 billion in transfers from Payments to the Health Care Trust Funds to HI and SMI. Medicaid and SCHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) for the HI Trust Fund totaling $131.5 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to the Health Care Trust Funds) of $62.5 billion, that matches monthly premiums paid by beneficiaries.

Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the year by budget function. HCFA had budget authority of $414.6 billion and unobligated balances of $1.4 billion. Total budgetary resources were $401.1 billion. Obligations of $399.7 billion leave available unobligated balances of $1.4 billion. Total outlays were $390.1 billion. Net outlays were $299 billion. The difference is $69.6 billion in the Payments to the Health Care Trust Funds Appropriation, which is appropriated from the general fund into the SMI trust fund, then expended as benefit payments; and $21.6 billion relating to collection of premiums.

Combined Statement of Financing

The Combined Statement of Financing is a reconciliation of the preceding statements. Obligation-based measures are used in the Combined Statement of Budgetary Resources, while accrual-based measures are used in the other statements, especially in the treatment of liabilities. HCFA's general ledger supports the Report on Budget Execution (SF-133) and the Combined Statement of Budgetary Resources. A liability not covered by budgetary resources may not be recorded as a funded liability in these budgetary accounts. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Combined

Statement of Financing in the line called Accrued Entitlement Benefit Costs.

Limitations of the Financial Statements

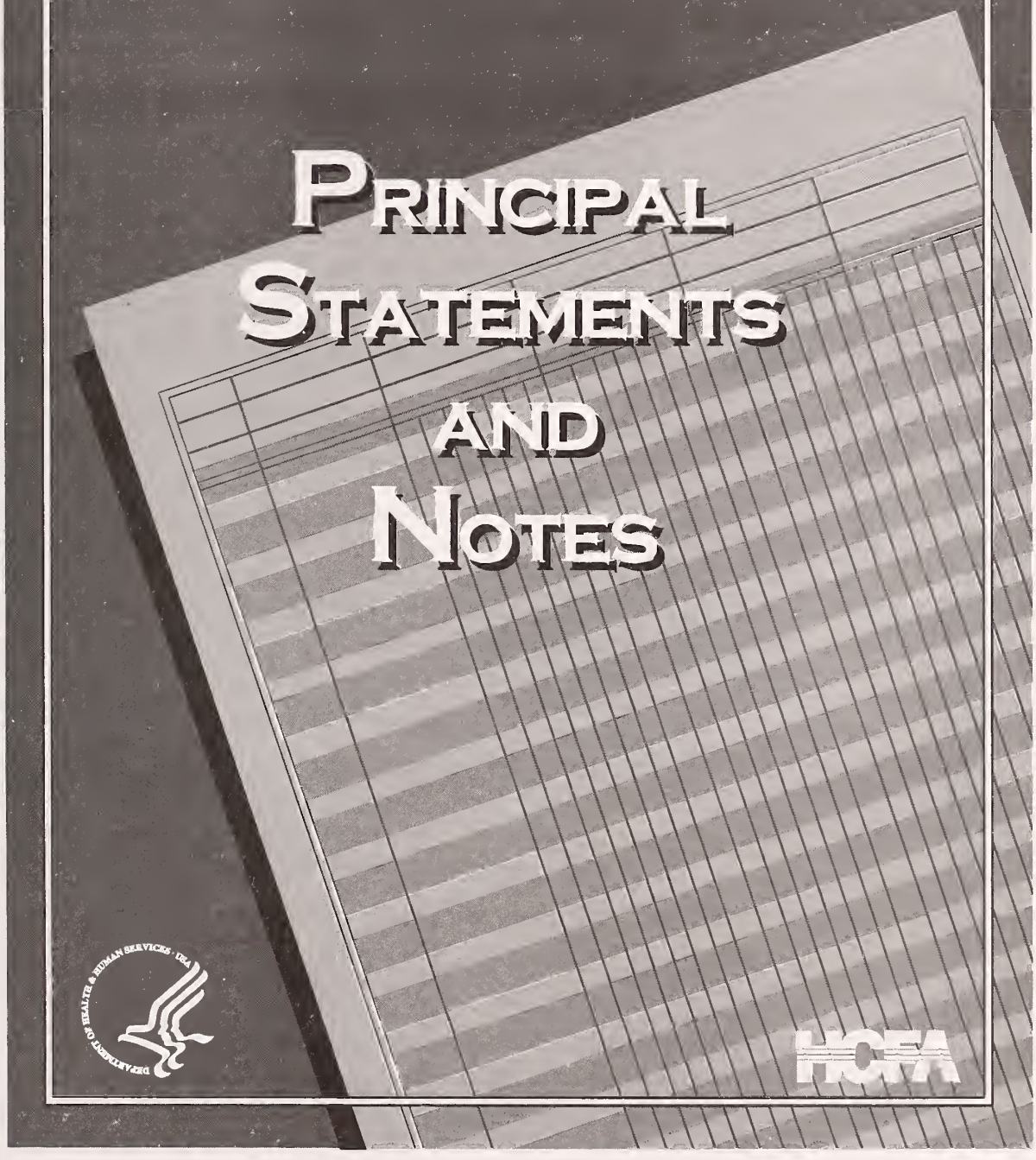
The financial statements have been prepared to report the financial position and results of operations of HCFA, pursuant to the requirements of 31 U.S.C. 3515(b) and the Chief Financial Officers Act of 1990, (P.L. 101-576).

These financial statements have been prepared from HCFA's general ledger and subsidiary reports and supplemented with financial data provided by the U.S. Treasury in accordance with the formats prescribed by the Office of Management and Budget. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the Budget of the U.S. Government and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis. The accuracy and propriety of the information contained in the principal financial statements and the quality of internal control rests with management.

U.S. Department of Health and Human Services

Health Care Financing Administration

Principal Statements and Notes



CONSOLIDATED BALANCE SHEET
As of September 30, 1999 (in millions)

	Consolidated Totals
ASSETS	
Entity Assets:	
Intragovernmental:	
Intragovernmental Assets:	
Fund Balances *(Note 2)*	$17,768
Trust Fund Investments *(Note 3)*	180,295
Anticipated Congressional Appropriation *(Note 4)*	6,030
Trust Fund Investment Interest Receivable	3,003
Total Intragovernmental Assets	207,096
Accounts Receivable, Net *(Note 5)*	4,249
Advances and Prepayments	129
Restricted Cash	56
Property and Equipment, Net	20
Total Entity Assets	**211,550**
Non-Entity Assets:	
Interest and Penalties Receivable, Net	60
TOTAL ASSETS	**$211,610**
LIABILITIES	
Liabilities Covered by Budgetary Resources:	
Intragovernmental:	
Intragovernmental Liabilities:	
Employment Tax Revenue Adjustment *(Note 6)*	$2,867
Other Intragovernmental Liabilities	237
Total Intragovernmental Liabilities	3,104
Entitlement Benefits Due and Payable *(Note 7)*	35,302
Other Liabilities	209
Total Liabilities Covered by Budgetary Resources	**38,615**
Liabilities not Covered by Budgetary Resources:	
Accrued Leave and Other Unfunded Liabilities	33
Total Liabilities not Covered by Budgetary Resources	**33**
TOTAL LIABILITIES	**$38,648**
NET POSITION	
Balances:	
Unexpended Appropriations *(Note 8)*	$8,082
Cumulative Results of Operations	164,880
TOTAL NET POSITION	**$172,962**
TOTAL LIABILITIES & NET POSITION	**$211,610**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF NET COST

Year Ended September 30, 1999 (in millions)

	MEDICARE	MEDICAID	Other	Consolidated Totals
PROGRAM/ACTIVITY COSTS				
Benefit Payments *(Note 9)*	$200,984	$108,896	$522	$310,402
(Includes estimated improper payments of $9.1-$17.9 billion)				
Other Program Costs	5,081	118	154	5,353
Total Program/Activity Costs *(Note 10)*	**206,065**	**109,014**	**676**	**315,755**
Less: Earned Revenues				
Premiums Collected *(Note 11)*	21,561			21,561
Other Earned Revenues	3		139	142
Total Earned Revenues	**21,564**		**139**	**21,703**
NET COST OF OPERATIONS	**$184,501**	**$109,014**	**$537**	**$294,052**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

Year Ended September 30, 1999 (in millions)

	MEDICARE	MEDICAID	Other	Consolidated Totals
Net Cost of Operations	**$184,501**	**$109,014**	**$537**	**$294,052**
Financing Sources (other than exchange revenues):				
Appropriations Used	69,846	108,897	522	179,265
Employment Tax Revenue *(Note 12)*	131,519			131,519
Interest on Trust Fund Investments	12,349			12,349
Trust Fund Draws	1,680	124	5	1,809
Revenue Transferred to Program Management	(1,809)			(1,809)
Balanced Budget Act of 1997 Recovery Impact	140			140
Other Revenues and Financing Sources *(Note 13)*	526	(5)	47	568
Total Financing Sources	**214,251**	**109,016**	**574**	**323,841**
Net Results of Operations	**29,750**	**2**	**37**	**29,789**
Net Change in Cumulative Results of Operations	**29,750**	**2**	**37**	**29,789**
Increase (Decrease) in Unexpended Appropriations *(Note 14)*	(758)	(902)	3,699	2,039
Change in Net Position	**28,992**	**(900)**	**3,736**	**31,828**
Net Position-Beginning of Period	135,813	962	4,359	141,134
Net Position-End of Period	**$164,805**	**$62**	**$8,095**	**$172,962**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF BUDGETARY RESOURCES
Year Ended September 30, 1999 (in millions)

	Combined Totals
Budgetary Resources:	
Budget authority	$414,587
Unobligated balances - beginning of period	165,216
Net transfers prior year balance, actual	(2)
Spending authority from offsetting collections	2,103
Adjustments	(180,748)
Total Budgetary Resources	**401,156**
Status of Budgetary Resources:	
Obligations incurred	399,734
Unobligated balances - available	1,275
Unobligated balances - not available	147
Total Status of Budgetary Resources	**401,156**
Outlays:	
Obligations incurred	399,734
Less: spending authority from offsetting collections and adjustments	(6,073)
Obligated balance, net - beginning of period	9,977
Obligated balance transferred, net	(110)
Less: obligated balance, net- end of period	(13,385)
Total Outlays	**$390,143**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF FINANCING

Year Ended September 30, 1999 (in millions)

	Combined Totals
RESOURCES USED TO FINANCE ACTIVITIES	
Budgetary	
Budgetary resources obligated for orders, delivery of goods and services to be received, or benefits to be provided to others	$399,734
Less: offsetting collections, and recoveries of prior-year authority	(5,936)
Net Budgetary Resources Used to Finance Activities	**393,798**
Non-budgetary	
Property received from others without reimbursement	1,869
Property given to others without reimbursement	(1,809)
Costs incurred by others for the entity without reimbursement	24
Net Non-budgetary Resources Used to Finance Activities	**84**
Total Resources Used to Finance Activities	**393,882**
RELATIONSHIP of TOTAL RESOURCES to the NET COST of OPERATIONS:	
Budgetary resources that fund expenses recognized in prior periods	39,570
Increase in budgetary resources obligated to order goods and services not yet received or benefits not yet provided.	4,555
Adjustments other than collections made to compute net budgetary resources that do not affect net cost of operations	
Recoveries of prior-year authority	(126)
Resources that do not affect net cost of operations	(585)
Resources that finance the acquisition of assets or liquidation of liabilities	(5)
Total Resources Used to Fund Items Not Part of the Net Cost of Operations	43,409
Resources Used to Finance the Net Cost of Operations	**350,473**
COMPONENTS NOT REQUIRING OR GENERATING RESOURCES	
Expenses or exchange revenue related to the disposition of assets or liabilities, or allocation of their costs over time:	
Expenses related to use of assets	(723)
Increase in exchange revenue receivable from the public	85
Increase in Restricted Cash	(5)
Trust Fund Premiums collected	(21,561)
Other	31
Expenses that will be financed with budgetary resources recognized in future periods:	
Accrued Entitlement Benefit Costs	35,302
Annual Leave expense from increase in annual leave liability	1
Other	295
Total Components Not Requiring or Generating Resources	**13,425**
NET COST OF OPERATIONS	**$363,898**

The accompanying notes are an integral part of these statements.

NOTE 1: Summary of Significant Accounting Policies

Reporting Entity

The Health Care Financing Administration (HCFA) is a separate financial reporting entity of the Department of Health and Human Services (HHS). The financial statements have been prepared to report the financial position and results of operations of HCFA, as required by the Chief Financial Officers Act of 1990. The statements were prepared from HCFA's accounting records in accordance with generally accepted accounting principles (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 97-01.

The financial statements cover all the programs administered by HCFA. The programs administered by HCFA are shown in two categories, Medicare and Health. The Medicare programs include:

Medicare Hospital Insurance (HI) Trust Fund

Medicare contractors are paid by HCFA to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. HCFA payments to managed care plans are also charged to this fund. The financial statements include HI Trust Fund activities administered by the Department of the Treasury (Treasury).

Medicare Supplementary Medical Insurance (SMI) Trust Fund

Medicare contractors are paid by HCFA to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI Trust Fund. HCFA payments to managed care plans are also charged to this fund. The financial statements include SMI Trust Fund activities administered by Treasury.

Medicare Integrity Program (MIP)

The Health Insurance Portability and Accountability Act, Public Law 104-191, established the MIP, codifying the program integrity activities previously known as "payment safeguards." This account is also called the Health Care Fraud and Abuse

Control (HCFAC) Program, or simply "Fraud and Abuse." The MIP contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The MIP is funded by the HI Trust Fund.

Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI Trust Funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). In addition, funds are provided by this appropriation to cover the Medicaid program's share of HCFA's administrative costs. To prevent duplicative reporting, the revenue and expenses of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

The Health programs include:

Medicaid

Medicaid, the health care program for low-income Americans, is administered by HCFA in partnership with the States. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of HCFA's share of States' Medicaid costs. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HCFA for the difference between approved expenses reported for the period and the grant awards previously issued.

The State Children's Health Insurance Program (SCHIP)

SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this new insurance coverage. The grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to implement SCHIP. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HCFA for the difference between approved expenses reported for the period and the grant awards previously issued.

Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund

The HMO Loan and Loan Guarantee Fund was originally established to provide working capital to HMOs during their initial period of operations and to guarantee loans made by private lenders to HMOs. The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, HCFA collects principal and interest payments from HMO borrowers, and, in turn, pays the FFB.

Program Management User Fees: Medicare + Choice, Clinical Laboratory Improvement Program, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare + Choice program that requires managed care plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. HCFA and the Public Health Service share responsibility for the CLIA program, with HCFA having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund.

Program Management Appropriation

The Program Management Appropriation provides HCFA with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI Trust Funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI Trust Fund to cover the Medicaid program's share of HCFA's administrative costs (see Note 9). User fees collected from managed care plans seeking Federal qualification and funds received from other federal agencies to reimburse HCFA for services performed for them are credited to the Program Management Appropriation.

The cost related to the Program Management Appropriation is allocated among all programs based on HCFA's cost allocation system. It is reported in the Medicare and Health columns of the Consolidating Statement of Net Cost in the Supplementary Financial Statement Section.

Basis of Presentation

The financial statements have been prepared to report the financial position and results of operations of HCFA, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990 (P.L. 101-576), and amended by the Government Management Reform Act of 1994.

These financial statements have been prepared from HCFA's general ledger in accordance with GAAP and the formats prescribed by the OMB Bulletin 97-01. Some amounts shown will differ from those in other financial documents, such as the Budget of the U.S. Government and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

Basis of Accounting

HCFA uses the Government's Standard General Ledger account structure and follows accounting policies and guidelines issued by HHS. The financial statements are prepared on an accrual basis. Individual accounting transactions are recorded using both the accrual basis and cash basis of accounting. Under the accrual method, expenses are recognized when resources are consumed, without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlayed. HCFA follows standard budgetary accounting principles that facilitate compliance with legal constraints and controls over the use of Federal funds.

HCFA uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal year end. Revenues are also recognized both when earned (without regard to receipt of cash) and, in the case of HI and SMI premiums, when collected. Employment taxes earmarked for the Medicare program are recorded on a cash basis.

HCFA uses the cash basis of accounting in the Medicaid program to record funds paid to the States during the fiscal year, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to HCFA as of the end of the fiscal year.

Consolidated Balance Sheet

The consolidated balance sheet presents amounts of future economic benefits owned or managed by HCFA (assets), amounts owed (liabilities), and amounts which comprise the difference (net position). The major components are described below.

Assets include entity assets, which are assets that HCFA holds and has the authority to use in its operations; and non-entity assets, which are assets that HCFA holds but does not have the authority to use. An example of non-entity assets are civil monetary penalties (CMP) receivables, which HCFA collects for the U.S. Government but does not have authority to spend.

Fund Balances are funds with Treasury that are primarily available to pay current liabilities. Cash receipts and disbursements are processed by Treasury. HCFA also maintains lockboxes at commercial banks for the deposit of SMI premiums from States and third parties and for collections from HMO plans.

Trust Fund Investments and Interest Receivable are investments and accrued interest on investments held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and has been adjusted to include an accrual for interest earned from July 1 to September 30.

Accounts Receivable, Net consists of amounts owed to HCFA by other Federal agencies and the public. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and/or an analysis of the outstanding balances.

Medicare Secondary Payer (MSP) Accounts Receivable (A/R) consists of amounts owed to Medicare by insurance companies, employers, beneficiaries, and/or providers for payments made by Medicare that should have been paid by the primary payer. MSP A/R represent entity receivables. Receipts are transferred to the HI or SMI Trust Fund upon collection. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the

outstanding balances.

Medicare Non-MSP A/R consists of amounts owed to Medicare by medical providers and others because Medicare made payments that were not due, for example, excess payments that were determined to have been made once provider cost reports were audited. Non-MSP A/R represent entity receivables and, once collected, are transferred to the HI or SMI Trust Fund. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

Advances and Prepayments are used to report advance payments made to health care providers. These occur when there are billing or claims processing problems and health providers ask for accelerated Medicare payments to minimize problems related to cash flow.

Restricted Cash is the total amount of time account balances at the Medicare contractors' commercial banks. The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against a Medicare Benefits account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks.

Property and Equipment (P&E) are recorded at full cost of purchase, including all costs incurred to bring the P&E to a form and location suitable for its intended use, net of accumulated depreciation. All P&E with an initial acquisition cost of $25,000 or more and an estimated useful life of 2 years or greater is capitalized. P&E is depreciated on a straight-line basis over the estimated useful life of the asset. Normal maintenance and repair costs are expensed as incurred.

Liabilities represent amounts owed by HCFA as the result of transactions that have occurred. In accordance with Public Law and existing Federal accounting standards, no liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare Hospital Insurance (HI) Trust Fund.

Liabilities funded by available budgetary resources include: (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of unexpired budget

authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. HCFA recognizes such liabilities for employee annual leave earned but not taken, and amounts billed by the Department of Labor for Federal Employee's Compensation Act (disability) payments. For HCFA revolving funds, all liabilities are funded as they occur.

Accounts Payable consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables such as worker's compensation (FECA) payments due to the Department of Labor.

Entitlement Benefits Due and Payable represent Medicare or Medicaid medical services incurred but not paid as of September 30. The Medicare estimate is developed by the Office of the Actuary (OACT) and is based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts. The estimate represents (1) claims incurred that may or may not have been submitted to the Medicare contractors and were not yet approved for payment, (2) claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (4) periodic interim payments, and (5) retroactive settlements of cost reports.

The Medicaid amount reported is the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. This information was provided by the States.

Other Unfunded Liabilities are the retirement plans utilized by HCFA employees; the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, HCFA makes matching contributions equal to 7 percent of pay. HCFA does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of the Office of Personnel Management.

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which HCFA is required to contribute 1 percent of pay and to match employee contributions up to an additional 4 percent of pay. For employees covered by FERS, HCFA also contributes the employer's matching share of Social Security taxes.

Net Position contains the following components:

Unexpended Appropriations include the portion of HCFA's appropriations represented by undelivered orders and unobligated balances.

Cumulative Results of Operations represent the net results of operations since the inception of the program plus the cumulative amount of prior period adjustments.

Consolidated Statement of Net Cost

The Consolidated Statement of Net Cost shows the components of the net cost of HCFA's operations for the period by program. Under GPRA, HCFA is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that HCFA administers are: Medicare, Medicaid, and SCHIP. The bulk of HCFA's expenses are allocated to these programs. MIP is included in Medicare. The costs related to the Program Management Appropriation are cost allocated to all three major components.

Program/Activity Costs represent the gross costs or expenses incurred by HCFA for all activities.

Benefit Payments are the payments by Medicare contractors, HCFA, and Medicaid State agencies to health care providers for their services.

Administrative Expenses represent the costs of doing business by HCFA and its partners.

Earned Revenues or exchange revenues arise when a Government entity provides goods and services to the public or to another Government entity for a fee.

Premiums Collected are used to finance SMI benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal government through the general fund appropriation, Payments to

the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Net Cost of Operations is the difference between the program's gross costs and its related exchange revenues.

Consolidated Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. Major components are described below.

Financing Sources (Other than Exchange Revenues) arise primarily from exercise of the Government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other Government entities, donations, and imputed financing.

Appropriations Used and Federal Matching Contributions are described in the Medicare Premiums section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. A transfer of general funds to the HI Trust Fund in an amount equal to Self-Employment Contribution Act (SECA) tax credits is made through the Payments to the Health Care Trust Funds Appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989.

Employment Tax Revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). Employees and employers were both required to contribute 1.45 percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contributed the full 2.9 percent of their net income.

Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the year. Budgetary Statements were developed for each of the budgetary accounts. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-HCFA eliminations in this statement.

Unobligated Balances - beginning of period represent funds available. These funds are primarily HI and SMI Trust Fund balances invested by the Treasury.

Budget Authority represents the funds available through appropriations, direct spending authority, obligations limitations, unobligated balances at the beginning of the period or transferred in during the period, spending authority from offsetting collections, and any adjustments to budgetary authority.

Obligations Incurred consists of expended authority, recoveries of prior year obligations and the change in undelivered orders.

Adjustments are increases or (decreases) to budgetary resources. Increases include recoveries of prior year obligations; decreases include budgetary resources temporarily not available, recissions, and cancellations of expired and no-year accounts.

Combined Statement of Financing

The Combined Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidated Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of HCFA's general ledger, which supports the Report on Budget Execution (SF-133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Combined Statement of Financing.

Use of Estimates in Preparing Financial Statements

Preparation of financial statements in accordance with Federal accounting standards requires HCFA to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

Intra-Governmental Relationships and Transactions

In the course of its operations, HCFA has relationships and financial transactions with numerous Federal agencies. For example, HCFA interacts with the Social Security Administration (SSA) and Treasury. SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing sources, and issues interest-bearing securities in exchange for the use of those monies. At the Government-wide level, the assets related to the trust funds on HCFA's financial statements and the corresponding liabilities on the Treasury's financial statements are eliminated.

Accounting Changes

The following accounting changes were made in the 1999 financial statements:

1) During FY 1999, OMB revised Circular A-34, clarifying the reporting for "Adjustments" and "Unobligated balances - available" on the Statement of Budgetary Resources. The change required that "Adjustments" include the portion of receipts collected in the current fiscal year for trust funds that is precluded from obligation due to Public Law 101-508. In FY 1998, these receipts were reported as "Unobligated balances - available" (for obligation). In FY 1999, these receipts are reported as (negative) amounts on the "Adjustments" under HI and SMI, and, additionally, HI and SMI must have no "Unobligated balances - available."

2) On the Consolidating Statement of Changes in Net Position, transfers made from the Payments to the Health Care Trust Funds to HI and SMI are reported as Financing Sources twice: (1) as "Appropriations Used" under HI and SMI and (2) as "Federal Matching Contribution (SMI) and "Other Revenues and Financing Sources" (HI). To avoid double reporting these Financing Sources, HCFA previously eliminated the "Appropriations Used" amounts. HCFA believes the proper elimination should be against the "Federal Matching Contribution" and "Other Revenues and Financing Sources," which will match the elimination of Intragovernmental Revenues with

Intragovernmental Expenses within HCFA. As a result, the "Federal Matching Contribution" line has been eliminated from the Consolidated Statement of Changes in Net Position.

3) HCFA implemented a number of policy changes in the reporting of delinquent acccounts receivables. Currently Not Reportable/Collectible is a new financial reporting category. While these debts are not reported on the financial statements, the Currently Not Reportable/Collectible process requires the use of collection tools of the Debt Collection Improvement Act of 1996. This allows delinquent debt to be worked until the end of its statutory collection life cycle. HCFA has adopted this policy as part of its effort to improve financial reporting and established a standard to manage and report delinquent debt.

The implementation of the revised policies and other initiatives undertaken this fiscal year described above, resulted in significant adjustments and write offs made to HCFA's accounts receivable balance. HCFA's financial reporting reflected additional adjustments, resulting from the validation efforts performed and revised policies and supplemental guidance provided by HCFA to the Medicare contractors.

In prior fiscal years, the allowance for uncollectible accounts was derived from data based on the last five years of collection experience. However, the implementation of the revised policies for reporting delinquent debt this fiscal year has precluded HCFA from using this same methodology. The allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity for the most current fiscal year, while taking into consideration the significant amount of accounts receivable balances that were removed from HCFA's financial statements.

Comparative Data

OMB Bulletin 97-01, "Form and Content of Agency Financial Statements" provides that comparative financial statements are permitted but not required until reporting periods beginning after September 30, 1999 (FY 2000). HCFA comparative financial statements are not presented for FY 1999.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 1999, HCFA has canceled over $107 million in cumulative obligations to FY 1994 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991 (P.L. 101-150). Based on the payments made in FY 1995 through 1999 related to canceled appropriations, HCFA anticipates an additional $1.5 million will be paid from current year funds for canceled obligations.

NOTE 2: Fund Balances (Dollars in Millions)

Entity Fund Balances:	Entity Assets		Consolidated
	Unrestricted	Restricted	Total
Trust Funds.....			
HI Trust Fund Balance *(1)*	$(15,336)	$34	$(15,302)
SMI Trust Fund Balance *(1)*	19,141		19,141
Revolving Funds.....			
HMO Loan *(2)*	11		11
CLIA *(2)*	110		110
Appropriated Funds.....			
Medicaid	5,870		5,870
SCHIP	7,912		7,912
Other Fund Types.....			
HCFA Suspense Account *(2)*	9		9
Program Management Reimbursables *(2)*	17		17
Total Entity Fund Balances	**$17,734**	**$34**	**$17,768**

(1) The Treasury Bureau of Public Debt (BPD) manages the HI and SMI Trust Funds on HCFA's behalf. Medicare revenues collected by the BPD are invested in interest-bearing Treasury securities that are earmarked for the Medicare program. The BPD redeems these securities periodically to make funds available for Medicare benefit payments. Each week, based on estimated Medicare benefit outlays, the BPD transfers funds from the Medicare Trust Funds into the Medicare transfer accounts. At the end of each month HCFA calculates the difference between actual Medicare benefit outlays and the estimated amounts transferred by BPD. If the estimate was too high and excess funds were deposited into the transfer accounts, funds are returned from the transfer accounts to the Medicare Trust Funds. If the estimate was too low and insufficient funds were deposited into the transfer accounts then additional funds are transferred from the Medicare Trust Funds into the transfer accounts. Because the HI and SMI transfer accounts do not earn interest, HCFA strives to keep their fund balances as close to zero as possible.

During FY 1999 a series of miscalculations caused the HI Trust Fund to be underdrawn by about $14 billion and the SMI Trust Fund to be overdrawn by about $18 billion. As a result of these miscalculations, HI earned excess interest of about $154 million and SMI lost interest earnings of about $237 million for FY 1999. The

mis-allocation of interest between the Medicare Trust Funds and the General Funds resulted in a net loss of zero to the Federal government.

HCFA believes that the Medicare Trust Funds should be made whole by reducing HI interest revenue by about $154 million and increasing SMI interest revenue by about $237 million. While HCFA adjusted the Medicare Trust Funds to restore the proper principal amounts in October 1999, adjustments for the interest related to these miscalculations had not been made as of January 2000. HCFA is pursuing with the Department of Health and Human Services and the Department of Treasury a method to restore the funding level that the trust funds would have had but for these miscalculations.

The restricted portion of the HI fund balance represents the remaining fund balance in the Payments to the Health Care Trust Funds appropriation, which is allocated to HI.

(2) These fund balances are reported in the Supplementary Financial Statement section under the "All Others" column of the Consolidating Balance Sheet.

NOTE 3: Trust Fund Investments (Dollars in Millions)

MEDICARE INVESTMENTS			
	Maturity Range	**Interest Range**	**Value**
HI			
Certificates	June 2000	6 1/4%	$15,366
Bonds	June 1999 to June 2014	5 7/8 - 10 3/8%	138,401
Total HI Investments			**$153,767**
SMI			
Bonds	June 2003 to June 2014	5 7/8 - 8 3/4%	$26,528
Total SMI Investments			**26,528**
Total Medicare Investments			**$180,295**

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicare program expenses by the programs is the net amount outstanding reported in the Consolidated Balance Sheet. This schedule summarizes the nature and amount of investments in the Medicare trust funds.

As discussed in Note 2, in October 1999, HCFA liquidated certain investments and transferred balances to restore the program HI and SMI Trust Fund balances.

Note 4: Anticipated Congressional Appropriation

HCFA has recorded a $6,030 million anticipated Congressional appropriation to cover liabilities incurred as of September 30 by the Medicaid program and the Payments to the Health Care Trust Funds appropriation, as discussed below:

Medicaid

Beginning in FY 1996, HCFA has accrued an expense and liability for Medicaid claims incurred but not reported (IBNR) as of September 30. In FY 1999, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $5,735 million. A review of appropriation language by HCFA's Office of General Counsel (OGC) has resulted in a determination that the Medicaid appropriation's indefinite authority provision allows for the entire IBNR amount to be reported as a funded liability. Consequently, HCFA has recorded a $5,735 million anticipated appropriation in FY 1999 for IBNR claims that exceed the available appropriation.

Payments to the Health Care Trust Funds

The SMI program is financed primarily by the general fund appropriation, Payments to the Health Care Trust Funds, and by monthly premiums paid by beneficiaries. Section 1844 of the Social Security Act authorizes funds to be appropriated from the general fund to match premiums payable "and deposited in the Trust Fund . . . " Section 1844 also outlines the ratio for the match and the method to make the trust funds whole if insufficient funds are available in the appropriation to match all SMI premiums received in the fiscal year. The appropriated amount is an estimate calculated annually by HCFA's OACT and can be insufficient in any particular fiscal year. In FY 1999, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. Subsequently, OACT has valued the unmatched amount as $295 million. When this occurs, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following year. Although the actual transfer of funds will occur in FY 2000, HCFA has reported the $295 million as revenues earned in FY 1999.

Note 5: Accounts Receivable, Net (Dollars in Millions)

	Medicare			All	Consolidated
	HI	SMI	Medicaid	Others	Total
Provider & Beneficiary Overpayments					
Accounts Receivable Principal	$4,919	$1,280			$6,199
Less: Allowance for Uncollectible Accounts	(2,178)	(495)			(2,673)
Accounts Receivable, Net	2,741	785			3,526
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	202	99			301
Less: Allowance for Uncollectible Accounts	(115)	(52)			(167)
Accounts Receivable, Net	87	47			134
CMPs & Other Restitutions					
Accounts Receivable Principal	67	193			260
Less: Allowance for Uncollectible Accounts	(35)	(16)			(51)
Accounts Receivable, Net	32	177			209
Fraud and Abuse					
Accounts Receivable Principal	46	92			138
Less: Allowance for Uncollectible Accounts	(46)	(92)			(138)
Accounts Receivable, Net	0	0			-
Managed Care					
Accounts Receivable Principal	10	48			58
Less: Allowance for Uncollectible Accounts	----	(5)			(5)
Accounts Receivable, Net	10	43			53
Medicare Premiums					
Accounts Receivable Principal	109	242			351
Less: Allowance for Uncollectible Accounts	(26)	(32)			(58)
Accounts Receivable, Net	83	210			293
Audit Disallowances					
Accounts Receivable Principal	1	3	$30		34
Less: Allowance for Uncollectible Accounts	----	----	(7)		(7)
Accounts Receivable, Net	1	3	23		27
Other Accounts Receivable					
Accounts Receivable Principal	2	2		$3	7
Less: Allowance for Uncollectible Accounts	----	----		----	----
Accounts Receivable, Net	2	2		3	7
Total Accounts Receivable Principal	**5,356**	**1,959**	**30**	**3**	**7,348**
Less: Allowance for Uncollectible Accounts	(2,400)	(692)	(7)		(3,099)
Total Accounts Receivable, Net	**$2,956**	**$1,267**	**$23**	**$3**	**$4,249**

Medicare accounts receivable are primarily composed of provider and beneficiary overpayments, and Medicare Secondary Payer (MSP) overpayments. The MSP receivables are composed of paid claims in which Medicare should have been the secondary rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount. Accounts receivable data were primarily obtained from data provided by the Medicare contractors.

Currently Not Reportable/Currently Not Collectible Debt

During FY 1999, HCFA performed extensive analysis of its accounts receivables, specifically relating to the likelihood of collecting delinquent debt and the need for writing off debt if the likelihood of collecting it was minimal. As a result, HCFA implemented a number of policy changes in the reporting of delinquent acccounts receivables.

Provisions within the Office of Management and Budget (OMB) Circular A-129, *Managing Federal Credit Programs,* allows an agency to move certain uncollectible delinquent debts into memorandum entries, which removes the receivable from the financial statements. HCFA developed a new policy and prescribed this criteria to properly reflect accounts receivable at their true economic value. The policy provided for certain debts to be written-off closed without any further collection activity or reclassified as Currently Not Reportable. (This is also referred to as Currently Not Reportable/Collectible). This category of debt will continue to be referred for collection and litigation, but will not be reported on the financial statements because of the unlikelihood of collecting it.

Currently Not Reportable/Collectible is a new financial reporting category. While these debts are not reported on the financial statements, the Currently Not Reportable/Collectible process permits and requires the use of collection tools of the Debt Collection Improvement Act of 1996. This allows delinquent debt to be worked until the end of its statutory collection life cycle. HCFA has adopted this policy as part of its effort to improve financial reporting and established a standard to manage and report delinquent debt.

Recognition of MSP Accounts Receivables

HCFA also reviewed its policy for the recognition of MSP group health plan (GHP) based accounts receivable because it is the largest single type of debt included in MSP receivables on the financial statements. These debts are generated primarily from the HCFA/Internal Revenue Service/SSA Data Match, and are directed at insurance companies or employers who should have been the primary payer.

Prior audit findings indicate that HCFA may have been overstating the GHP portion of the MSP receivables by reporting them when legal liability is established rather than at some

later point in time when further information regarding the amount of the debt may be available.

HCFA reviewed its policy on the identification of MSP receivables to ensure that these debts are booked at the appropriate value and concluded that all MSP accounts receivable will continue to be recorded on the financial statements as of the date the MSP recovery demand letter is issued. However, the MSP accounts receivable ending balance will reflect an adjustment for expected reductions to GHP accounts receivable for situations where HCFA receives valid documented defenses to its recovery demands.

Write Offs and Adjustments

The implementation of the revised policies and other initiatives undertaken this fiscal year described above, resulted in significant adjustments and write offs made to HCFA's accounts receivable balance. HCFA's financial reporting reflected additional adjustments, resulting from the validation efforts performed and revised policies and supplemental guidance provided by HCFA to the Medicare contractors.

The accounts receivable ending balance also reflects approximately $3.0 billion of accounts receivable (principal and interest) that were written off HCFA's financial statements this fiscal year. The majority of this amount, about $2.1 billion, represents MSP debt that has accumulated over many years, during which time Medicare payments have totaled over a trillion dollars. About $2.7 billion of this write-off amount, $2.1 billion of MSP and $600 million of non-MSP accounts receivable, have been reclassified as Currently Not Reportable debt, on which collection efforts will still continue. The remainder represents accounts receivable amounts written off where collection action has been terminated.

In prior fiscal years, the allowance for uncollectible accounts was derived from data based on the last five years of collection experience. However, the implementation of the revised policies for reporting delinquent debt this fiscal year has precluded HCFA from using this same methodology. The allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity for the most current fiscal year, while taking into consideration the significant amount of accounts receivable balances that were removed from HCFA's financial statements.

Note 6: Employment Tax Adjustment

Section 1817(a) of the Social Security Act requires that Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) taxes be transferred periodically from the general fund in Treasury to the HI Trust Fund. However, employers' reports of earnings subject to these taxes are only received by the Social Security Administration (SSA) quarterly and annually. As a result, the employment taxes transferred to the trust funds daily are initially based on estimates. These transfers are later adjusted as quarterly and annual employer reports of actual earnings amounts are received by the Internal Revenue Service and SSA, respectively. SSA certified to Treasury the amount of wages paid for December 1998 and prior quarters, the self-employment taxes collected for calendar year 1997 and prior, and the respective tax rates applicable. On the basis of this information, the HI Trust Fund was adjusted by ($2,626 million) for FICA employment taxes transferred on the estimated basis and adjusted by ($241 million) for SECA taxes transferred on the estimated basis.

Note 7: Entitlement Benefits Due and Payable (Dollars in Millions)

	Medicare				Consolidated
	HI	SMI	Total	Medicaid	Total
Medicare Benefits Payable *(1)*	$13,201	$10,386	$23,587		$23,587
Demonstration Projects and HMO Benefits	53	33	86		86
Medicare Integrity Program	3		3		3
Medicaid Benefits Payable *(2)*				$11,500	11,500
Medicaid Audit/Program Disallowances *(3)*				126	126
Total Entitlement Benefits Due and Payable	**$13,257**	**$10,419**	**$23,676**	**$11,626**	**$35,302**

(1) Medicare benefits payable consists of $23.6 billion estimate by HCFA's Office of the Actuary of Medicare services incurred but not paid, as of September 30, 1999.

(2) Medicaid benefits payable of $11.5 billion is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to HCFA as of September 30, 1999.

(3) Medicaid audit and program disallowances of $126 million are contingent liabilities that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to HCFA. HCFA will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. HCFA defers the payment of these claims until the State provides additional supporting data. Based on historical data, HCFA expects to eventually pay approximately 44.2 percent of total contingent liabilities. Therefore, of the total contingent liabilities of $285 million, HCFA expects to pay approximately $126 million.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 1998, there were 9,927 PRRB cases under appeal. A total of 4,080 new cases were filed in FY 1999. The PRRB rendered decisions on 72 cases in FY 1999 and 3,995 additional cases were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 72 cases that were decided in FY 1999, a reasonable liability estimate cannot be projected for the value of the

9,940 cases remaining on appeal as of September 30, 1999. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

Note 8: Unexpended Appropriations (Dollars in Millions)

	Medicare				All	Consolidated
	HI	SMI	Medicaid	SCHIP	Others	Total
Unobligated						
Available			$60		$12	$72
Unavailable	$34					34
Undelivered Orders				$7,960	16	7,976
Total Unexpended Appropriations	**$34**		**$60**	**$7,960**	**$28**	**$8,082**

Note 9: Medicare Benefit Payments

Medicare Claims Estimated Improper Payments

Federal government audits require the review of programs for compliance with Federal laws and regulations. Accordingly, the OIG reviewed a statistically valid sample of Medicare claims to determine that claims were paid properly by Medicare contractors, and that services were actually performed and were medically necessary. Medicare, like other insurers, makes payments based on a standard claims form. The internal claims process involves reviewing claims as billed and paying the correct amount for the services rendered. The claims submitted for payment to Medicare contractors contained no visible errors. However, when the medical review asked for documentation from providers to support their claims, there was a 7.97 percent error rate with a dollar value in the range of $9.1-$17.9 billion ($13.5 billion midpoint). The majority of the errors fell into four broad categories: lack of medical necessity, insufficient or no documentation, incorrect coding, and noncovered/unallowable services.

Cost Report Settlement Process

The cost report settlement process represents the value of final outlays to providers based on fiscal intermediary (FI) audits, reviews and final settlements of Medicare cost reports. All institutional providers are required to file Medicare cost reports. For providers paid under the prospective payment system (PPS), the cost report includes costs that are not covered

under PPS, such as disproportionate share hospital payments, indirect medical education payments, and other indirect costs. For providers paid on a cost basis, the cost report represents the total costs incurred by the provider for medical services to patients and reflects the final distribution of these costs to the Medicare program.

In 1999, 34,791 cost reports totaling $110.1 billion were reviewed. Approximately $82 billion represented inpatient claims to PPS providers. These inpatient claims were included in prior years' claims testing that resulted in the determination of the Medicare claims improper payment error rate. The cost report settlements, therefore, focused on the remaining non-PPS balance of about $28 billion.

1999 Cost Report Summary
(Dollars in millions)

	Desk Reviews and Other	Audits	Total
Cost Reports	28,045	6,746	34,791
Costs Claimed	$41,271	$68,858	$110,129
Disallowed	$1,084	$1,632	$2,716

The $2.7 billion disallowed represents 10 percent of the $28 billion non-PPS balance. Based on the current disallowance rates, if the full-scope audits were expanded to include the entire universe, the total amount disallowed would range from $2.7 billion to $3.3 billion. Therefore, by limiting the amount of full-scope audits that were conducted, HCFA may have overpaid providers by as much as $600 million.

Potential Liability

HCFA routinely processes and settles cost reports for institutional providers. As part of this process some providers have filed suits challenging aspects of the cost report settlement process. HCFA cannot reasonably estimate the probability of the providers successfully winning their suits nor the potential liability for the Department. However, in the opinion of management, the resolution of these matters will not have a material impact on the results of operations and financial condition of HCFA.

Note 10: Total Program/Activity Costs (By Object Class) (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	SCHIP and Others	Combined Totals	Intra-HCFA Eliminations	Consolidated Totals
PROGRAM COSTS								
Medicare								
Insurance Claims and Indemnities								
Fee for Service	$102,649	$60,977	$163,626			$163,626		$163,626
Managed Care	20,243	17,115	37,358			37,358		37,358
Payments to the Health Care Trust Funds	7,366	62,480	69,846			69,846	$(69,846)	
Medicaid and SCHIP								
Grants and Subsidies				$108,896	$522	109,418		109,418
Total Program Costs	**$130,258**	**$140,572**	**$270,830**	**$108,896**	**$522**	**$380,248**	**$(69,846)**	**$310,402**
OPERATING COSTS								
Administrative								
Personal Services and Benefits	$651	$633	$1,284	$21	$4	$1,309		$1,309
Contractual Services	569	818	1,387	87	3	1,477		1,477
Grants and Subsidies	6	12	18	1		19		19
Travel and Transportation	4	7	11	1		12		12
Rental and Utilities	18	36	54	4		58		58
Printing and Reproduction	2	4	6	1		7		7
Supplies and Materials	1	2	3			3		3
Equipment	3	7	10	1		11		11
Total Administrative Costs	**$1,254**	**$1,519**	**$2,773**	**$116**	**$7**	**$2,896**		**$2,896**
Depreciation and Amortization	$2	$3	$5	$1		**$6**		**$6**
Bad Debts and Writeoffs	1,374	159	1,533	1		**1,534**		**1,534**
Medicare Integrity Program	746		746			**746**		**746**
Millenium (Y2K) Costs					$19	**19**		**19**
Imputed Cost Subsidies	8	15	23			**23**		**23**
CLIA Program Costs					128	**128**		**128**
Other Costs		1	1			**1**		**1**
Total Costs	**$133,642**	**$142,269**	**$275,911**	**$109,014**	**$676**	**$385,601**	**$(69,846)**	**$315,755**

For purposes of financial statement presentation, non-HCFA administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. In this regard, the SSA reported $78.9 million of Property and Equipment, (Net) attributable to the Medicare program as of September 30, 1999. This amount is not included in HCFA's Consolidated Balance Sheet as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 1999 to pay for this activity are included in this section as an administrative expense to the Medicare program. The SSA administrative costs are reported to HCFA by Treasury. These expenses are also reported by SSA on their FY 1999 Annual Financial Statement. HCFA's administrative costs have

been allocated to the Medicare and Medicaid programs based on the HCFA cost allocation system. Administrative costs allocated to the Medicare program include $1.2 billion paid to Medicare contractors to carry out their responsibilities as HCFA's agents in the administration of the Medicare program.

The chart below details the Administrative Expenses by agency. HCFA is only one of several agencies that charge some administrative expenses to Medicare.

Administrative Expenses (Dollars in Millions)

	Medicare				SCHIP and	Consolidated
	HI	SMI	Total	Medicaid	Others	Total
Administrative Expenses by Agency						
Treasury	$48		$48			$48
SSA	496	$430	926			926
HCFA	523	1,040	1,563	$116	$7	1,686
Peer Review Organizations	176	36	212			212
Other	11	13	24			24
Total Administrative Expenses	**$1,254**	**$1,519**	**$2,773**	**$116**	**$7**	**$2,896**

Note 11: Premiums Collected and Federal Matching Contribution

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was $43.80 from October 1998 through December 1998 and is $45.50, beginning January 1999. Premiums collected from beneficiaries totaled $20.2 billion in FY 1999 and were matched by a $62.2 billion contribution from the Federal government.

The amount of the appropriation is based on an estimate calculated annually by HCFA's Office of the Actuary and can be insufficient in any particular year. In FY 1999, the appropriation was insufficient by $295 million to match all premiums collected. As such, the matching ceased prior to the close of the fiscal year. In cases like this, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following fiscal year.

Note 12: Employment Tax Revenue

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employees' wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the HI Trust Fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

Note 13: Other Revenues and Financing Sources (Dollars in Millions)

	Medicare			All	Combined	Intra-HCFA	Consolidated
	HI	SMI	Medicaid	Others	Total	Eliminations	Total
Fraud and Abuse Appropriation	$66				$66	$(66)	
Transfer-Uninsured Coverage	652				652	(652)	
Program Management Admin. Expense *(1)*	96				96	(96)	
Military Service Contribution	71				71		$71
Income Tax OASDI Benefits *(2)*	6,552				6,552	(6,552)	
Railroad Retirement Principal	388				388		388
Civil/Criminal Fines and Penalties	114				114		114
Gifts and Miscellaneous	4	$7			11		11
Imputed Financing	7	15	$1		23		23
Millennium Y2K Financing				$19	19		19
Revaluation of Equity Accounts	(28)	(52)	(6)	28	(58)		(58)
Total Other Revenues and Financing Sources	**$7,922**	**$(30)**	**$(5)**	**$47**	**$7,934**	**$(7,366)**	**$568**

(1) During FY 1999, the Payments to the Health Care Trust Funds appropriation paid the HI Trust Fund $96 million to cover the Medicaid program's share of HCFA's administrative costs.

(2) The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of Old Age Survivors and Disability Insurance (OASDI) benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent. The revenues, resulting from this increase, are transferred to the HI Trust Fund.

As explained in Accounting Changes (2), HCFA has eliminated the double reporting of Payments to the Health Care Trust Funds and HI and SMI against the Federal Matching Contribution (SMI) and Other Revenues and Financing Sources (HI). Previously, HCFA eliminated the Payments to the Health Care Trust Funds Appropriations Used.

Funds are obtained from the HI and SMI Trust Funds as cash is needed to pay for Program Management appropriation expenses. During FY 1999, a total of $1,809 million was obtained from the trust funds to cover cash outlays. Of this amount, $1,452 million was needed to pay for expenses incurred against current year obligations and $357 million was needed for expenses incurred against prior year obligations.

Note 14: Increase (Decrease) in Unexpended Appropriations (Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	SCHIP	All Others	Consolidated Total
Current Year Warrants and Anticipated Appropriations Exceeding (Less Than) Appropriated Capital Used	$24	$(782)	$(758)	$(902)	$3,725	$(26)	$2,039
Total Increase (Decrease) in Unexpended Appropriations	**$24**	**$(782)**	**$(758)**	**$(902)**	**$3,725**	**$(26)**	**$2,039**

The unexpended appropriations increased due to the FY 1999 SCHIP appropriation's exceeding FY 1999 expenditures.

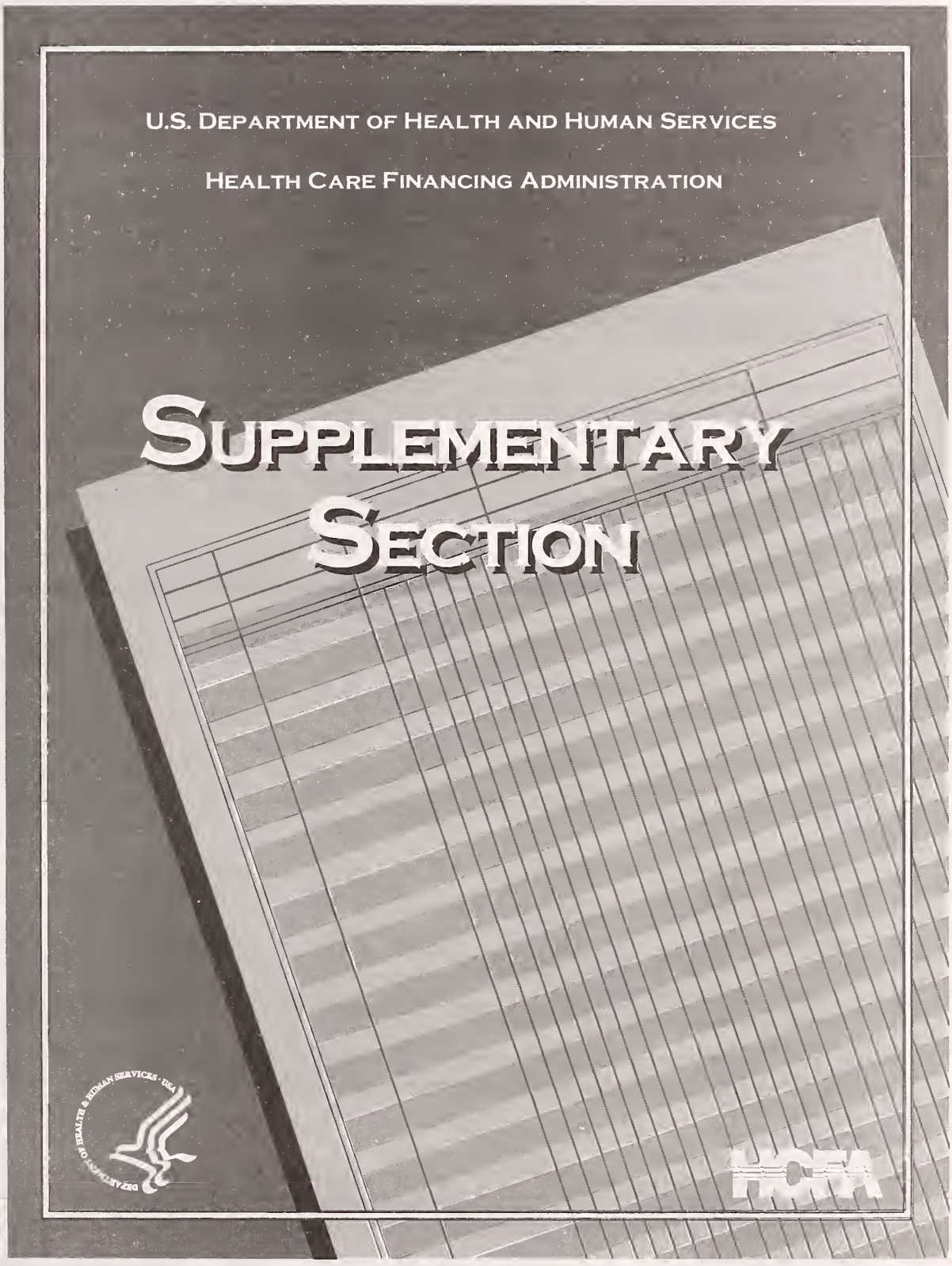
Note 15: Gross Cost and Earned Revenue by Budget Functional Classification (Dollars in Millions)

	Medicare	Health	Combined Total	Intra-HCFA Eliminations	Consolidated Total
Intragovernmental Costs	$70,782	$43	$70,825	$(69,846)	$979
With the Public	205,129	109,647	314,776		314,776
Gross Cost	275,911	109,690	385,601		315,755
Less: Earned Revenue	(21,564)	(139)	(21,703)		(21,703)
Net Cost	**$254,347**	**$109,551**	**$363,898**	**$(69,846)**	**$294,052**

U.S. Department of Health and Human Services

Health Care Financing Administration

Supplementary Section



CONSOLIDATING BALANCE SHEET
As of September 30, 1999 (in millions)

	MEDICARE		HEALTH			Combined
	HI	SMI	Medicaid	SCHIP	Other	Total
ASSETS						
Entity Assets:						
Intragovernmental Assets:						
Fund Balances	$(15,302)	$19,141	$5,870	$7,912	$147	$17,768
Trust Fund (TF) Investments	153,767	26,528				180,295
Anticipated Congressional Appropriation		590	5,735			6,325
Anticipated Transfer from SMI			60			60
TF Investment Interest Receivable	2,542	461				3,003
Total Intragovernmental Assets	141,007	46,720	11,665	7,912	147	207,451
Accounts Receivable, Net	2,956	1,267	23		3	4,249
Advances and Prepayments	24	46	5	48	6	129
Restricted Cash	5	51				56
Property and Equipment, Net	7	12	1			20
Total Entity Assets	**143,999**	**48,096**	**11,694**	**7,960**	**156**	**211,905**
Non-Entity Assets:						
Interest and Penalties Receivable, Net					**60**	**60**
TOTAL ASSETS	**$143,999**	**$48,096**	**$11,694**	**$7,960**	**$216**	**$211,965**

	MEDICARE		HEALTH			Combined
	HI	SMI	Medicaid	SCHIP	Other	Total
LIABILITIES						
Liabilities Covered by Budgetary Resources						
Intragovernmental Liabilities:						
Liability for Allocation Transfer		$355				$355
Employment Tax Revenue Adjustment	$2,867					2,867
Other Intragovernmental Liabilities	54	112	$1		$70	237
Total Intragovernmental Liabilities	2,921	467	1		70	3,459
Entitlement Benefits Due and Payable	13,257	10,419	11,626			35,302
Other Liabilities	56	139	3		11	209
Total Liabilities Covered by Budgetary Resources	**16,234**	**11,025**	**11,630**		**81**	**38,970**
Liabilities not Covered by Budgetary Resources:						
Accrued Leave and Other Liabilities	10	21	2			33
Total Liabilities not Covered by Budgetary Resources	**10**	**21**	**2**			**33**
TOTAL LIABILITIES	**$16,244**	**$11,046**	**$11,632**		**$81**	**$39,003**
NET POSITION						
Balances:						
Unexpended Appropriations	$34		$60	$7,960	$28	$8,082
Cumulative Results of Operations	127,721	$37,050	2		107	164,880
TOTAL NET POSITION	**$127,755**	**$37,050**	**$62**	**$7,960**	**$135**	**$172,962**
TOTAL LIABILITIES & NET POSITION	**$143,999**	**$48,096**	**$11,694**	**$7,960**	**$216**	**$211,965**

CONSOLIDATING BALANCE SHEET **As of September 30, 1999** (in millions)	**Combined Total**	**Intra-HCFA Eliminations**	**Consolidated Totals**
ASSETS			
Entity Assets:			
Intragovernmental Assets:			
Fund Balances	$17,768		$17,768
Trust Fund (TF) Investments	180,295		180,295
Anticipated Congressional Appropriation	6,325	$(295)	6,030
Anticipated Transfer from SMI	60	(60)	
TF Investment Interest Receivable	3,003		3,003
Total Intragovernmental Assets	207,451	(355)	207,096
Accounts Receivable, Net	4,249		4,249
Advances and Prepayments	129		129
Restricted Cash	56		56
Property and Equipment, Net	20		20
Total Entity Assets	**211,905**	**(355)**	**211,550**
Non-Entity Assets:			
Interest and Penalties Receivable, Net	**60**		**60**
TOTAL ASSETS	**$211,965**	**$(355)**	**$211,610**

	Combined Total	**HCFA Eliminations**	**Consolidated Totals**
LIABILITIES			
Liabilities Covered by Budgetary Resources			
Intragovernmental Liabilities:			
Liability for Allocation Transfer	$355	$(355)	
Employment Tax Revenue Adjustment	2,867		$2,867
Other Intragovernmental Liabilities	237		237
Total Intragovernmental Liabilities	3,459	(355)	3,104
Entitlement Benefits Due and Payable	35,302		35,302
Other Liabilities	209		209
Total Liabilities Covered by Budgetary Resources	**38,970**	**(355)**	**38,615**
Liabilities not Covered by Budgetary Resources:			
Accrued Leave and Other Liabilities	33		33
Total Liabilities not Covered by Budgetary Resources	**33**		**33**
TOTAL LIABILITIES	**$39,003**	**$(355)**	**$38,648**
NET POSITION			
Balances:			
Unexpended Appropriations	$8,082		$8,082
Cumulative Results of Operations	164,880		164,880
TOTAL NET POSITION	**$172,962**		**$172,962**
TOTAL LIABILITIES & NET POSITION	**$211,965**	**$(355)**	**$211,610**

CONSOLIDATING STATEMENT OF NET COST

Year Ended September 30, 1999	MEDICARE			HEALTH			Combined
(in millions)	HI	SMI	Total	Medicaid	SCHIP	Other	Total
PROGRAM/ACTIVITY COSTS							
Benefit Payments *(Includes estimated improper payments of $9.1-$17.9 billion)*	$122,892	$78,092	$200,984	$108,896	$522		$310,402
Payments to the Health Care TF	7,366	62,480	69,846				69,846
Other Program Costs	3,384	1,697	5,081	118	$5	$149	5,353
Total Program/Activity Costs	**133,642**	**142,269**	**275,911**	**109,014**	**527**	**149**	**385,601**
Less: Earned Revenues							
Premiums Collected	1,401	20,160	21,561				21,561
Other Earned Revenues	3		3			139	142
Total Earned Revenues	**1,404**	**20,160**	**21,564**			**139**	**21,703**
NET COST OF OPERATIONS	**$132,238**	**$122,109**	**$254,347**	**$109,014**	**$527**	**$10**	**$363,898**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

Year Ended September 30, 1999	MEDICARE			HEALTH			Combined
(in millions)	HI	SMI	Total	Medicaid	SCHIP	Other	Total
Net Cost of Operations	**$132,238**	**$122,109**	**$254,347**	**$109,014**	**$527**	**$10**	**$363,898**
Financing Sources (other than exchange revenues):							
Appropriations Used	7,366	62,480	69,846	108,897	522		179,265
Employment Tax Revenue	131,519		131,519				131,519
Federal Matching Contribution		62,480	62,480				62,480
Interest on Trust Fund Investments	9,604	2,745	12,349				12,349
Trust Fund Draws	562	1,118	1,680	124	5		1,809
Revenue Transferred to Prog. Mgt.	(741)	(1,068)	(1,809)				(1,809)
Balanced Budget Act Recovery		140	140				140
Other Revenues & Financing Sources	7,922	(30)	7,892	(5)		47	7,934
Total Financing Sources	**156,232**	**127,865**	**284,097**	**109,016**	**527**	**47**	**393,687**
Net Results of Operations	**23,994**	**5,756**	**29,750**	**2**		**37**	**29,789**
Net Change in Cumulative Results of Operations	**23,994**	**5,756**	**29,750**	**2**		**37**	**29,789**
Increase (Decrease) in Unexpended Appropriations	24	(782)	(758)	(902)	3,725	(26)	2,039
Change in Net Position	**24,018**	**4,974**	**28,992**	**(900)**	**3,725**	**11**	**31,828**
Net Position-Beginning of Period	103,737	32,076	135,813	962	4,235	124	141,134
Net Position-End of Period	**$127,755**	**$37,050**	**$164,805**	**$62**	**$7,960**	**$135**	**$172,962**

CONSOLIDATING STATEMENT OF NET COST Year Ended September 30, 1999 (in millions)	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
PROGRAM/ACTIVITY COSTS			
Benefit Payments *(Includes estimated improper payments of $9.1-$17.9 billion)*	$310,402		$310,402
Payments to the Health Care TF	69,846	$(69,846)	
Other Program Costs	5,353		5,353
Total Program/Activity Costs	**385,601**	**(69,846)**	**315,755**
Less: Earned Revenues			
Premiums Collected	21,561		21,561
Other Earned Revenues	142		142
Total Earned Revenues	**21,703**		**21,703**
NET COST OF OPERATIONS	**$363,898**	**$(69,846)**	**$294,052**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION Year Ended September 30, 1999 (in millions)	Combined Total	Intra-HCFA Eliminations	Consolidated Totals
Net Cost of Operations	**$363,898**	**$(69,846)**	**$294,052**
Financing Sources (other than exchange revenues):			
Appropriations Used	179,265		179,265
Employment Tax Revenue	131,519		131,519
Federal Matching Contribution	62,480	(62,480)	
Interest on Trust Fund Investments	12,349		12,349
Trust Fund Draws	1,809		1,809
Revenue Transferred to Prog. Mgt.	(1,809)		(1,809)
Balanced Budget Act Recovery	140		140
Other Revenues & Financing Sources	7,934	(7,366)	568
Total Financing Sources	**393,687**	**(69,846)**	**323,841**
Net Results of Operations	**29,789**		**29,789**
Net Change in Cumulative Results of Operations	**29,789**		**29,789**
Increase (Decrease) in Unexpended Appropriations	2,039		2,039
Change in Net Position	**31,828**		**31,828**
Net Position-Beginning of Period	141,134		141,134
Net Position-End of Period	**$172,962**		**$172,962**

COMBINING STATEMENT OF BUDGETARY RESOURCES

Year Ended September 30, 1999 (in millions)	**HI**	**SMI**	**HCFAC**	**Payments to Trust Funds**	**Program Mgt.**
Budgetary Resources:					
Budget authority	$152,333	$85,278	$764	$69,571	
Unobligated balances - beginning of period	116,762	40,875	30	849	$192
Net Transfers prior year balance, actual					
Spending authority from offsetting collections			3		2,038
Adjustments	(138,222)	(45,615)		(835)	132
Total Budgetary Resources	**130,873**	**80,538**	**797**	**69,585**	**2,362**
Status of Budgetary Resources:					
Obligations incurred	130,873	80,538	771	69,551	2,128
Unobligated balances - available			26	34	98
Unobligated balances - not available					136
Total Status of Budgetary Resources	**130,873**	**80,538**	**797**	**69,585**	**2,362**
Outlays:					
Obligations incurred	130,873	80,538	771	69,551	2,128
Less: spending authority from offsetting collections and adjustments			(3)		(2,216)
Obligated balance, net - beginning of period	352	14	122		240
Obligated balance transferred, net					(110)
Less: obligated balance, net- end of period	(465)	(34)	(149)		(74)
Total Outlays	**$130,760**	**$80,518**	**$741**	**$69,551**	**$(32)**

COMBINING STATEMENT OF BUDGETARY RESOURCES

Year Ended September 30, 1999

(in millions)	Medicaid	SCHIP	HMO Loan	Combined Totals
Budgetary Resources:				
Budget authority	$102,394	$4,247		$414,587
Unobligated balances - beginning of period	6,012	485	$11	165,216
Net Transfers prior year balance, actual			(2)	(2)
Spending authority from offsetting collection:	60		2	2,103
Adjustments	3,792			(180,748)
Total Budgetary Resources	**112,258**	**4,732**	**11**	**401,156**
Status of Budgetary Resources:				
Obligations incurred	111,141	4,732		399,734
Unobligated balances - available	1,117			1,275
Unobligated balances - not available			11	147
Total Status of Budgetary Resources	**112,258**	**4,732**	**11**	**401,156**
Outlays:				
Obligations incurred	111,141	4,732		399,734
Less: spending authority from offsetting collections and adjustments	(3,852)		(2)	(6,073)
Obligated balance, net - beginning of period	5,504	3,745		9,977
Obligated balance transferred, net				(110)
Less: obligated balance, net- end of period	(4,751)	(7,912)		(13,385)
Total Outlays	**$108,042**	**$565**	**$(2)**	**$390,143**

INTRAGOVERNMENTAL BALANCES
Year Ended September 30, 1999
(in millions)

Intra-governmental Assets	*TFM Dept. Code	Fund Bal. with Treasury	Investments	Interest/ Accounts Receivable	Other
Agency					
Department of the Treasury	20	$17,768	$183,298	$6,030	
Department of Health and Human Services	75			295	$60
		$17,768	**$183,298**	**$6,325**	**$60**

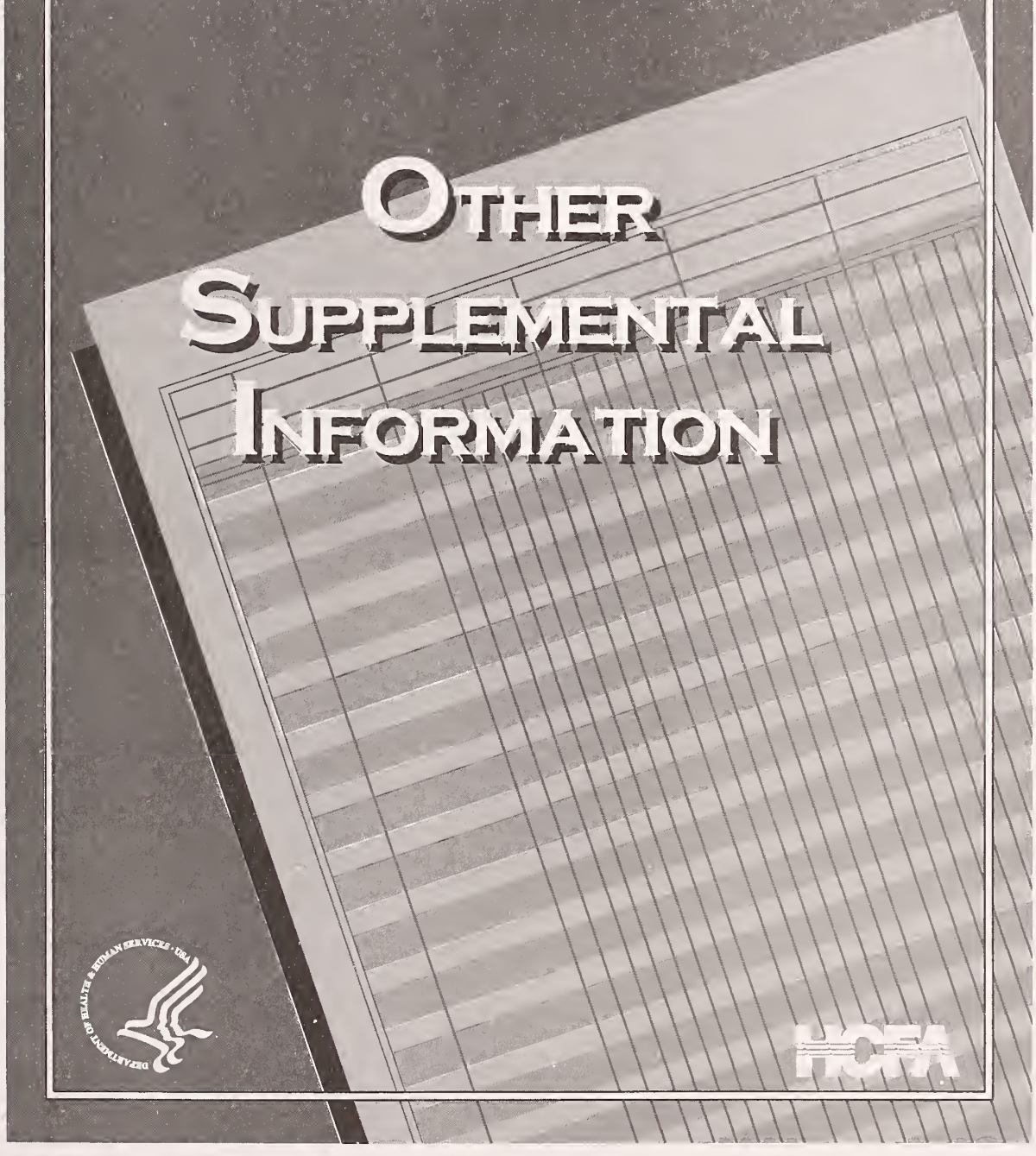
Intra-governmental Liabilities	*TFM Dept. Code	Accounts Payable	Environmental and Disposal Costs	Debt	Other
Agency					
Department of Labor	16				$2
Department of the Treasury	20			$2	3,083
Office of Personnel Management	24				2
General Services Administration	47				5
Department of Health and Human Services	75				355
All Other Federal Agencies	4,18				10
				$2	**$3,457**

* Treasury Financial Manual

U.S. Department of Health and Human Services

Health Care Financing Administration

Other Supplemental Information



HCFA

HOSPITAL INSURANCE TRUST FUND PROJECTIONS

(in billions)

Calendar Year	Total Income	Total Expenditures	Change in Fund	Fund at Year End	Assets to [1] Expenditures (percent)
1998	$140.5	$135.8	$4.8	$120.4	85
1999	145.7	145.2	0.5	120.9	83
2000	150.8	142.5	8.3	129.2	85
2001	157.3	150.6	6.8	136.0	86
2002	163.9	157.2	6.7	142.6	86
2003	171.0	165.6	5.3	147.9	86
2004	178.6	174.4	4.2	152.2	85
2005	187.3	184.6	2.7	154.9	82
2006	196.1	196.0	0.1	155.0	79
2007	205.9	208.1	-2.2	152.7	74
2008	215.7	220.8	-5.1	147.6	69

[1] Ratio of assets in the fund at the beginning of the year to expenditures during the year.

Note: Totals do not necessarily equal the sums of rounded components.

Reflects intermediate assumptions of the 1999 Annual Report of the Trustees of the HI Trust fund.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND PROJECTIONS

(in billions)

Calendar Year	Total Income	Total Expenditures	Change in Fund	Fund at Year End
1998	$87.7	$77.6	$10.1	$46.2
1999	79.6	85.0	-5.4	40.8
2000	94.5	97.3	-2.8	38.0
2001	102.3	103.2	-0.8	37.2
2002	111.7	111.8	-0.2	37.1
2003	122.4	121.2	1.2	38.3
2004	130.5	130.0	0.6	38.9
2005	139.4	138.7	0.7	39.6
2006	150.9	149.2	1.8	41.4
2007	164.1	161.0	3.1	44.5
2008	177.7	174.2	3.5	47.9

Reflects intermediate assumptions of the 1999 Annual Report of the Trustees of the SMI Trust fund.

FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

Material Weakness ***1. Bookkeeping Errors in Fund Balance with Treasury – HI/SMI Trust Fund Transfer*** - During FY 1999, a series of bookkeeping errors caused the Medicare HI Trust Fund to be underdrawn by $14 billion and the SMI Trust Fund to be overdrawn by $18 billion. As a result of these errors, the HI Trust Fund earned excess interest in the amount of about $154 million and the SMI Trust Fund lost interest earnings in the amount of about $237 million for FY 1999. The misallocation of interest between the Medicare Trust Funds and Treasury's General Fund resulted in a net loss of zero to the Federal government.

The Medicare Trust Funds are invested in interest-bearing securities while benefit payments are paid out of non-interest bearing transfer accounts. Each week, based on estimated Medicare benefit outlays, the Department of the Treasury transfers (deposits) funds from the Medicare Trust Funds into the transfer accounts to pay Medicare contractors. At the end of each month, HCFA determines actual Medicare benefit outlays paid to Medicare contractors. During the last 9 months of FY 1999, proper reconciliation of the amount needed to be placed into the transfer accounts to actual Medicare contractor outlays did not occur. It appears that, because of insufficient training, staff did not understand that the large month-end transfer account balances were indicative of problems in the adjustment process.

As part of HCFA's corrective action plan to address this issue, steps have been taken to correct the error by making the necessary transactions to increase the balance of the HI transfer account and to decrease the balance of the SMI transfer account. HCFA is in the process of seeking approval/authority to reduce the HI Trust Fund interest revenue and to increase the SMI Trust Fund interest revenue. HCFA performed a detailed analysis of the Trust Fund account activity and processes affecting this account to determine the reason for these internal control weaknesses and to eliminate them in the future. Consequently, we are further implementing procedures that will ensure that employees involved in the process have the appropriate level of expertise and that each person involved in the process fully understands his/her assigned duties. Additionally, HCFA has instituted protocols to provide qualified and continuous supervision to ensure that employees adequately perform their assigned duties, and has established a formal system of monthly reconciliations and analyses of key financial data that includes readily available supporting documentation and senior management approval.

Material Weakness ***2. Improve Financial Reporting to Properly Account for Medicare Accounts Receivable and Other Financial Information*** - The OIG has not been able to provide assurance as to the reasonableness and accuracy of the accounts receivable in HCFA's financial statements reported by Medicare contractors due to the lack of documentation to support receivable activity. A revised corrective action plan was implemented during FY 1999 to address this issue. In FY 1999, HCFA worked diligently to improve the financial reporting of its accounts receivable and other financial information at contractor sites. As a result, we have achieved many of our goals including: the issuance to all contractors of revised Financial Reporting Policies, the development and issuance of clear policies on write-offs and adjustments, and the development of a revised policy for identifying and reporting MSP receivables.

However, many Medicare contractors remain limited in their financial reporting because they still lack general ledger systems that incorporate double entry bookkeeping. As a result, some Medicare contractors are still unable to adequately and consistently support their financial reporting activities in accordance with HCFA policies.

HCFA continues to provide instructions and guidance to the Medicare contractors on reconciling their quarterly financial reports to existing HCFA data to ensure accurate reporting. As HCFA progresses toward the long-term goal of developing an integrated financial management system, we continue to provide training and guidance to Medicare contractors regarding good financial reporting through educational activities, internal audits and self-assessments.

Material Weakness ***3a. Medicare Contractors Systems Application Controls***
Three weaknesses were noticed in the application controls for Medicare contractors:

One fiscal intermediary had developed and implemented an override library that gave locally changed programs higher execution priorities over the standard Fiscal Intermediary Shared System (FISS) programs provided by the FISS maintainer;

At one fiscal intermediary, the programmers made local changes to the FISS program outside of the Program Assistance Request (PAR) process. Program changes performed locally are not subjected to the same documentation, authorization, testing, quality assurance, and other requirements present in the standard PAR process;

The Medicare Contractor System (MCS) is the carrier shared system. The MCS application contains numerous edits and audits. Although the carriers do not have the MCS source code, the application, by design, allows them to deactivate almost all of the edits in the application, including mandatory HCFA edits.

The identified weaknesses related to the FISS and MCS are currently being addressed. The specific local site that made the changes to the FISS code took actions to formally document the changes. As a long-term solution, the process will be enhanced to limit overrides and to provide reasonable assurance that only authorized access to source codes and programs is permitted. This will require the development and implementation of policies and procedures for safeguarding programs/systems that support claims processing and financial functions. Suggested control objectives have been provided to Medicare contractors for consideration as part of their internal control certification process for FY 2000.

Contractors have access to source codes to allow them to take immediate action in emergency situations to resolve abnormal program ends that would otherwise potentially cause serious payment to processing delays and to accommodate individual intermediary requirements such as writing special printing hardware interfaces to handle print utilities. HCFA is beginning development of EDP strategies that do not require HCFA to release source codes but continue to allow contractors to take immediate action to resolve processing problems.

Material Weakness ***3b. Medicare EDP Controls – Systems/Access Controls to Limit the Number of Data Base Administrators (DBAs)/Applications Developers Who Can Directly Update Production Data*** - Direct command-line access to the M204 database has been granted to approximately 150 applications developers and DBAs. With the knowledge of file names and database update passwords, these developers can intentionally or inadvertently modify or update the data structures within specific regions of the M204 database. The M204 database product is used to store data for many of HCFA's sensitive applications, including, but not limited to, the Automated Payment Plan System, Enrollment Database, and Group Health Plan applications.

HCFA will use the utility product SIRSAFE to enhance M204 security controls. A HCFA workgroup developed and provided training on SIRSAFE to the Group Health Plans system developers and owners in November 1999. Because of Y2K priorities and deadlines, HCFA was unable to meet its December 1999 implementation target date. The implementation process for SIRSAFE began in January 2000. Training for the other M204 developers and owners was conducted in January 2000. A detailed project plan has been developed for this effort. Also activities have been planned for intensifying training, awareness and Medicare contractor oversight in the year 2000.

ADMINISTRATIVE FUNDING

HCFA's administrative costs are less than one percent of total expenditures. In the past, HCFA has been placed in a difficult position because the agency's resources have been straight-lined (in constant dollars) while the scope and magnitude of the programs it administers increased. This was caused by the budget scoring rules which totally separated

mandatory and discretionary spending, with Medicare and Medicaid benefit dollars being on the mandatory side, while the money used to administer these programs was on the discretionary side. Thus, while the benefit payments were growing, the dollars available to administer them were not. Actions to remedy this situation have resulted in a variety of funding mechanisms. Most of HCFA's claims payment and management oversight operations are funded through an annual appropriation; certain quality control functions, primarily the Peer Review Organizations and the Medicare Integrity Programs, are funded through direct trust fund draws; and numerous other activities are funded through a variety of user fees. In 1999, administrative expenses were $2,896 million. HCFA spent $1,686 million and the balance was spent by other Federal agencies.

User fees are currently collected to fund the activities to (1) develop and disseminate comparative health plan information, (2) survey and certify laboratories under CLIA, (3) pay for sales of data from HCFA's numerous databases, and (4) pay for sales of FOIA material. Unless set by statute, these fees are set to cover the costs of doing business and are reassessed at least every two years. Income received from user fees in 1999 ranged from $3 million for FOIA and others, to $36 million for CLIA, and $95 million for Medicare+Choice. Beginning in 1998, a legislatively mandated user fee was collected monthly from each managed care organization to implement the BBA information provisions of Medicare+Choice designed to enhance beneficiary choices.

STATEMENT OF ACCOUNT FOR HI TRUST FUND INVESTMENTS DESCRIPTION OF HOLDINGS AS OF SEPTEMBER 30, 1999

U.S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6.125% maturing June 30, 2000	$ 11,019,575,000.00	$ 11,019,575,000.00	0.00
6.250% maturing June 30, 2000	33,217,909,000.00	17,851,671,000.00	$ 15,366,238,000.00
Total Certificates of Indebtedness:	**$ 44,237,484,000.00**	**$ 28,871,246,000.00**	**$ 15,366,238,000.00**

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
13.750% due June 30, 1999	$ 850,544,000.00	$ 850,544,000.00	0.00
10.375% due June 30, 2000	1,277,566,000.00	0.00	$ 1,277,566,000.00
10.375% due June 30, 1999	427,022,000.00	427,022,000.00	0.00
9.250% due June 30, 2003	4,229,944,000.00	0.00	4,229,944,000.00
9.250% due June 30, 2002	1,034,542,000.00	0.00	1,034,542,000.00
9.250% due June 30, 2001	1,034,542,000.00	0.00	1,034,542,000.00
9.250% due June 30, 2000	1,034,542,000.00	0.00	1,034,542,000.00
9.250% due June 30, 1999	1,034,542,000.00	1,034,542,000.00	0.00
8.750% due June 30, 2005	6,415,695,000.00	0.00	6,415,695,000.00
8.750% due June 30, 2004	6,415,695,000.00	0.00	6,415,695,000.00
8.750% due June 30, 2003	2,185,751,000.00	0.00	2,185,751,000.00
8.750% due June 30, 2002	2,185,751,000.00	0.00	2,185,751,000.00
8.750% due June 30, 2001	2,185,751,000.00	0.00	2,185,751,000.00
8.750% due June 30, 2000	2,185,751,000.00	0.00	2,185,751,000.00
8.750% due June 30, 1999	2,185,751,000.00	2,185,751,000.00	0.00
8.625% due June 30, 2002	3,195,402,000.00	0.00	3,195,402,000.00
8.625% due June 30, 2001	686,250,000.00	0.00	686,250,000.00
8.625% due June 30, 2000	686,250,000.00	0.00	686,250,000.00
8.625% due June 30, 1999	686,250,000.00	686,250,000.00	0.00
8.375% due June 30, 2001	2,509,152,000.00	0.00	2,509,152,000.00
8.375% due June 30, 2000	1,231,586,000.00	0.00	1,231,586,000.00
8.375% due June 30, 1999	1,231,586,000.00	1,231,586,000.00	0.00
8.125% due June 30, 2006	7,316,968,000.00	103,302,000.00	7,213,666,000.00
8.125% due June 30, 2005	901,273,000.00	0.00	901,273,000.00
8.125% due June 30, 2004	901,273,000.00	0.00	901,273,000.00
8.125% due June 30, 2003	901,273,000.00	0.00	901,273,000.00
8.125% due June 30, 2002	901,274,000.00	0.00	901,274,000.00
8.125% due June 30, 2001	901,274,000.00	0.00	901,274,000.00
8.125% due June 30, 2000	901,274,000.00	0.00	901,274,000.00
8.125% due June 30, 1999	901,274,000.00	797,972,000.00	103,302,000.00
7.375% due June 30, 2007	8,184,929,000.00	0.00	8,184,929,000.00
7.375% due June 30, 2006	867,961,000.00	0.00	867,961,000.00
7.375% due June 30, 2005	867,961,000.00	0.00	867,961,000.00
7.375% due June 30, 2004	867,961,000.00	0.00	867,961,000.00
7.375% due June 30, 2003	867,961,000.00	0.00	867,961,000.00
7.375% due June 30, 2002	867,960,000.00	0.00	867,960,000.00

Continued

U. S. TREASURY SPECIAL ISSUES (continued)

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
7.375% due June 30, 2001	$ 867,960,000.00	0.00	$ 867,960,000.00
7.375% due June 30, 2000	867,961,000.00	$ 69,372,000.00	798,589,000.00
7.375% due June 30, 1999	867,961,000.00	867,961,000.00	0.00
7.250% due June 30, 2009	8,773,256,000.00	0.00	8,773,256,000.00
7.250% due June 30, 2008	225,130,000.00	0.00	225,130,000.00
7.250% due June 30, 2007	225,130,000.00	0.00	225,130,000.00
7.250% due June 30, 2006	225,129,000.00	0.00	225,129,000.00
7.250% due June 30, 2005	225,129,000.00	0.00	225,129,000.00
7.250% due June 30, 2004	225,129,000.00	0.00	225,129,000.00
7.250% due June 30, 2003	225,129,000.00	0.00	225,129,000.00
7.250% due June 30, 2002	225,129,000.00	0.00	225,129,000.00
7.250% due June 30, 2001	225,129,000.00	0.00	225,129,000.00
7.250% due June 30, 2000	225,129,000.00	225,129,000.00	0.00
7.000% due June 30, 2011	3,368,466,000.00	0.00	3,368,466,000.00
6.875% due June 30, 2011	2,166,172,000.00	0.00	2,166,172,000.00
6.500% due June 30, 2010	9,037,246,000.00	0.00	9,037,246,000.00
6.500% due June 30, 2009	263,990,000.00	0.00	263,990,000.00
6.500% due June 30, 2008	263,990,000.00	0.00	263,990,000.00
6.500% due June 30, 2007	263,990,000.00	0.00	263,990,000.00
6.500% due June 30, 2006	263,990,000.00	0.00	263,990,000.00
6.500% due June 30, 2005	263,990,000.00	0.00	263,990,000.00
6.500% due June 30, 2004	263,990,000.00	0.00	263,990,000.00
6.500% due June 30, 2003	263,990,000.00	0.00	263,990,000.00
6.500% due June 30, 2002	263,990,000.00	0.00	263,990,000.00
6.500% due June 30, 2001	263,990,000.00	0.00	263,990,000.00
6.500% due June 30, 2000	263,990,000.00	263,990,000.00	0.00
6.250% due June 30, 2008	8,548,126,000.00	0.00	8,548,126,000.00
6.250% due June 30, 2007	363,197,000.00	0.00	363,197,000.00
6.250% due June 30, 2006	363,198,000.00	0.00	363,198,000.00
6.250% due June 30, 2005	363,198,000.00	0.00	363,198,000.00
6.250% due June 30, 2004	363,198,000.00	0.00	363,198,000.00
6.250% due June 30, 2003	363,198,000.00	0.00	363,198,000.00
6.250% due June 30, 2002	363,198,000.00	0.00	363,198,000.00
6.250% due June 30, 2001	363,198,000.00	0.00	363,198,000.00
6.250% due June 30, 2000	363,197,000.00	363,197,000.00	0.00
6.000% due June 30, 2014	25,892,572,000.00	268,845,000.00	25,623,727,000.00
5.875% due June 30, 2012	11,272,706,000.00	2,518,249,000.00	8,754,457,000.00
Total Bonds:	**$ 150,294,552,000.00**	**$ 11,893,712,000.00**	**$ 138,400,840,000.00**
Total U. S. Treasury Special Issues:	**$ 194,532,036,000.00**	**$ 40,764,958,000.00**	**$ 153,767,078,000.00**

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS DESCRIPTION OF HOLDINGS AS OF SEPTEMBER 30, 1999

U. S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6.125% maturing June 30, 2000	$ 6,929,200,000.00	$ 6,929,200,000.00	$0.00
6.250% maturing June 30, 2000	13,794,316,000.00	13,794,316,000.00	0.00
Total Certificates of Indebtedness:	**$ 20,723,516,000.00**	**$ 20,723,516,000.00**	**$0.00**

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
8.750% due June 30, 2005	$ 991,433,000.00	$0.00	$ 991,433,000.00
8.750% due June 30, 2004	991,433,000.00	0.00	991,433,000.00
8.750% due June 30, 2003	991,433,000.00	310,335,000.00	681,098,000.00
8.750% due June 30, 2002	991,433,000.00	991,433,000.00	0.00
8.125% due June 30, 2006	1,218,813,000.00	0.00	1,218,813,000.00
8.125% due June 30, 2005	227,380,000.00	0.00	227,380,000.00
8.125% due June 30, 2004	227,381,000.00	0.00	227,381,000.00
8.125% due June 30, 2003	227,381,000.00	227,381,000.00	0.00
7.375% due June 30, 2007	1,293,107,000.00	0.00	1,293,107,000.00
7.375% due June 30, 2006	74,295,000.00	0.00	74,295,000.00
7.375% due June 30, 2005	74,295,000.00	0.00	74,295,000.00
7.375% due June 30, 2004	74,294,000.00	0.00	74,294,000.00
7.375% due June 30, 2003	74,294,000.00	74,294,000.00	0.00
7.250% due June 30, 2009	1,570,476,000.00	0.00	1,570,476,000.00
7.250% due June 30, 2008	47,113,000.00	0.00	47,113,000.00
7.250% due June 30, 2007	47,112,000.00	0.00	47,112,000.00
7.250% due June 30, 2006	47,112,000.00	0.00	47,112,000.00
7.250% due June 30, 2005	47,112,000.00	0.00	47,112,000.00
7.250% due June 30, 2004	47,112,000.00	0.00	47,112,000.00
7.250% due June 30, 2003	47,112,000.00	47,112,000.00	0.00
7.000% due June 30, 2011	1,659,860,000.00	0.00	1,659,860,000.00
7.000% due June 30, 2010	1,659,860,000.00	0.00	1,659,860,000.00
7.000% due June 30, 2009	89,384,000.00	0.00	89,384,000.00
7.000& due June 30, 2008	89,384,000.00	0.00	89,384,000.00
7.000% due June 30, 2007	89,384,000.00	0.00	89,384,000.00
7.000% due June 30, 2006	89,385,000.00	0.00	89,385,000.00
7.000% due June 30, 2005	89,385,000.00	0.00	89,385,000.00
7.000% due June 30, 2004	89,385,000.00	0.00	89,385,000.00
7.000% due June 30, 2003	89,385,000.00	89,385,000.00	0.00
7.000% due June 30, 2002	867,936,000.00	867,936,000.00	0.00
7.000% due June 30, 2001	1,659,861,000.00	1,659,861,000.00	0.00
7.000% due June 30, 2000	1,659,861,000.00	1,659,861,000.00	0.00
7.000% due June 30, 1999	1,659,861,000.00	1,659,861,000.00	0.00
7.000% due June 30, 1998	1,659,861,000.00	1,659,861,000.00	0.00
6.875% due June 30, 2012	2,227,470,000.00	567,609,000.00	1,659,861,000.00
6.875% due June 30, 2011	567,610,000.00	0.00	567,610,000.00
6.875% due June 30, 2010	567,610,000.00	0.00	567,610,000.00
6.875% due June 30, 2009	567,610,000.00	0.00	567,610,000.00
6.875% due June 30, 2008	567,610,000.00	0.00	567,610,000.00

Continued

U. S. TREASURY SPECIAL ISSUES (continued)

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6.875% due June 30, 2007	$ 567,610,000.00	$0.00	$ 567,610,000.00
6.875% due June 30, 2006	567,609,000.00	0.00	567,609,000.00
6.875% due June 30, 2005	567,609,000.00	0.00	567,609,000.00
6.875% due June 30, 2004	567,609,000.00	0.00	567,609,000.00
6.875% due June 30, 2003	567,609,000.00	0.00	567,609,000.00
6.875% due June 30, 2002	567,609,000.00	567,609,000.00	0.00
6.875% due June 30, 2001	567,609,000.00	567,609,000.00	0.00
6.875% due June 30, 2000	567,609,000.00	567,609,000.00	0.00
6.875% due June 30, 1999	567,609,000.00	567,609,000.00	0.00
6.250% due June 30, 2008	1,523,363,000.00	0.00	1,523,363,000.00
6.250% due June 30, 2007	230,257,000.00	0.00	230,257,000.00
6.250% due June 30, 2006	230,256,000.00	0.00	230,256,000.00
6.250% due June 30, 2005	230,256,000.00	0.00	230,256,000.00
6.250% due June 30, 2004	230,256,000.00	0.00	230,256,000.00
6.250% due June 30, 2003	230,256,000.00	230,256,000.00	0.00
6.000% due June 30, 2014	1,585,164,000.00	1,003,851,000.00	581,313,000.00
5.875% due June 30, 2013	6,714,226,000.00	1,495,585,000.00	5,218,641,000.00
Total Bonds:	**$ 41,343,339,000.00**	**$ 14,815,057,000.00**	**$ 26,528,282,000.00**
Total U.S. Treasury Special Issues:	**$ 62,066,855,000.00**	**$ 35,538,573,000.00**	**$ 26,528,282,000.00**

PUBLIC AND INTRAGOVERNMENTAL COSTS

Year Ended September 30, 1999

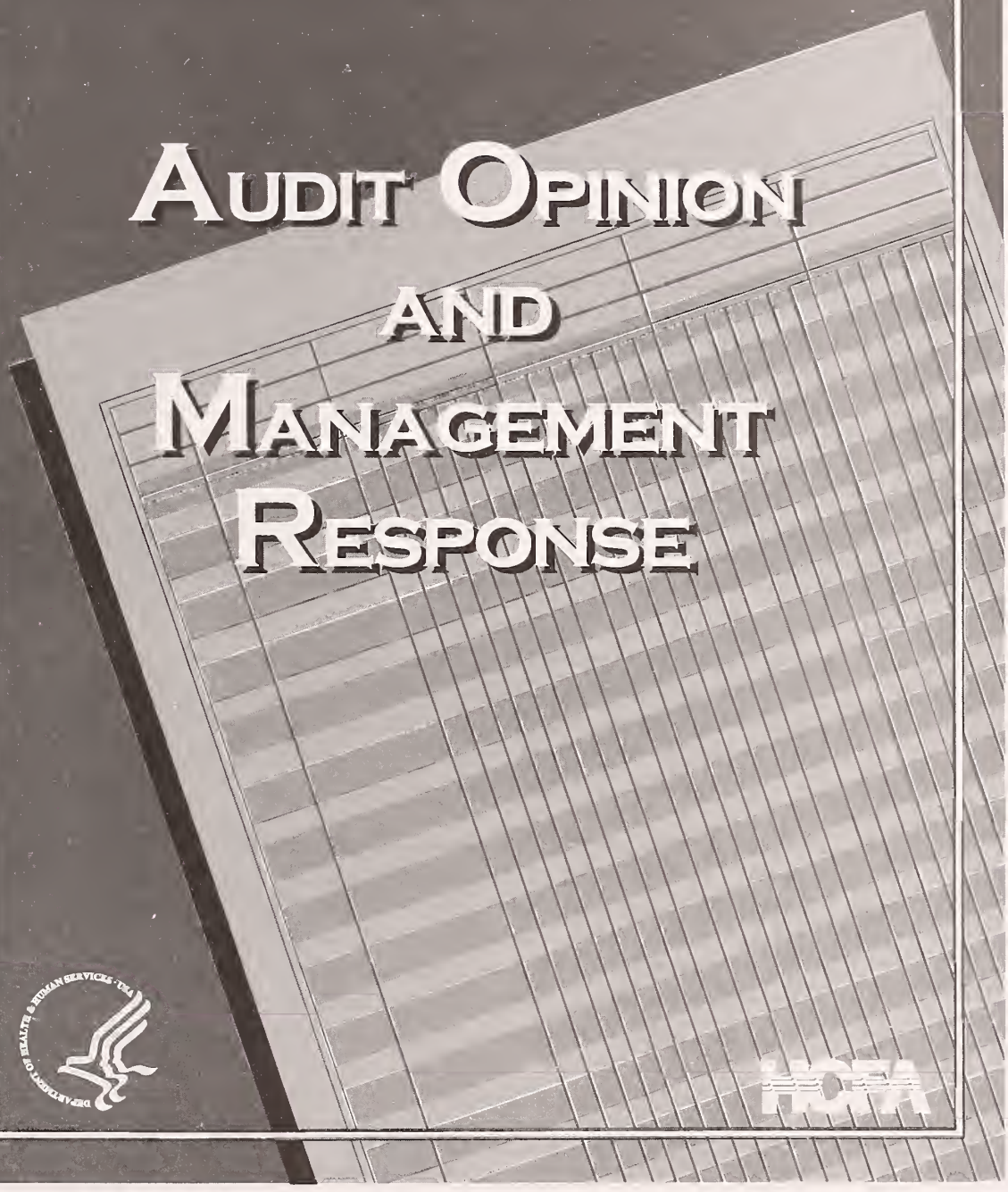
(in millions)

PROGRAMS/ACTIVITIES	Intra-Governmental	With the Public	Gross Costs	Less: Earned Revenue	Combined Net Program/ Activity Costs
GPRA Programs					
Medicare	$70,782	$205,129	$275,911	$(21,564)	$254,347
Medicaid		109,014	109,014		109,014
Other	43	633	676	(139)	537
Total Public and Intragovernmental Costs	**$70,825**	**$314,776**	**$385,601**	**$(21,703)**	**$363,898**

U.S. Department of Health and Human Services

Health Care Financing Administration

Audit Opinion and Management Response



Memorandum

Date FEB 28 2000

From June Gibbs Brown
Inspector General

Subject Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1999 (CIN: A-17-00-00500)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

The attached final report presents the results of the audit of the Fiscal Year (FY) 1999 financial statements of the Health Care Financing Administration (HCFA). The firm Ernst & Young LLP (E&Y) undertook the audit in support of the Departmentwide financial statement audit by the Office of Inspector General (OIG) and in accordance with the Government Management Reform Act of 1994. The OIG exercised technical oversight and quality control of the audit. The overall audit objective was to determine whether the HCFA principal financial statements were fairly presented in all material respects.

In the auditors' opinion, the HCFA financial statements present fairly, in all material respects, the financial position of HCFA as of September 30, 1999, and its net costs, changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for the fiscal year then ended in conformity with generally accepted accounting principles.

The HCFA is to be commended for achieving this important milestone. However, as discussed in the auditors' report on internal controls, material weaknesses continue in financial systems and reporting, Medicare accounts receivable, and electronic data processing controls. Correction of these weaknesses will require HCFA's sustained commitment.

- **Financial Systems and Reporting (Repeat Condition).** While substantial progress has been made in providing reliable financial information, HCFA continues to be impaired by the absence of a fully integrated financial management system to accumulate, analyze, and report financial information in a timely manner. The HCFA issued its first financial statements in mid-December 1999 and then made billions of dollars in adjustments to payables and receivables before producing the final, auditable financial statements in late January 2000.

  Routine reconciliation and analysis of accounts, two key controls for timely detection of material errors and irregularities, were not always used. For example,

HCFA did not independently verify the Medicare Supplementary Medical Insurance (SMI) trust fund and the Hospital Insurance (HI) trust fund balances, did not reconcile these accounts at a sufficiently detailed level, and used ineffective methodologies to calculate SMI and HI transfers. The result was an overfunding and underfunding of the trust fund accounts and a significant net loss of interest earnings. Similarly, HCFA did not periodically validate the National Claims History File to ensure the existence and completeness of the data. Due to a breakdown in controls, the file was missing 100 million claims valued at more than $13 billion.

While corrective action is underway or completed, these problems should have been detected during the normal business cycle through routine reconciliation and analysis of accounts.

- **Medicare Accounts Receivable (Repeat Condition)** The opinion on HCFA's FY 1998 financial statements was qualified mainly because Medicare contractors could not support beginning accounts receivable balances, reported incorrect activity and collections, and could not reconcile reported ending balances with subsidiary records. During FY 1999, HCFA initiated a major effort to validate and document accounts receivable. While the receivables balance was fairly presented as of the year's end, HCFA and the Medicare contractors still did not have adequate internal controls to ensure that future receivables would be properly reflected in their financial reports.

- **Medicare Electronic Data Processing (Repeat Condition).** The HCFA relies on extensive electronic data processing (EDP) operations at both its central office and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. Although HCFA fully recognized the importance of these controls, its FY 1999 resources were devoted in large part to addressing Year 2000 readiness issues. As a consequence, not all prior-year EDP findings were resolved.

The HCFA's comments on the draft of this report have been incorporated where appropriate. Officials in your office have concurred with the recommendations and are in the process of taking corrective action. We would like to thank you and your staff for the outstanding cooperation and assistance in working with us and E&Y on these most complex and challenging problems.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

To facilitate identification, please refer to Common Identification Number A-17-00-00500 in all correspondence relating to this report.

Attachment

cc:
John J. Callahan
Assistant Secretary
for Management and Budget

George H. Strader
Deputy Assistant Secretary, Finance

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE FINANCIAL STATEMENT AUDIT OF THE HEALTH CARE FINANCING ADMINISTRATION FOR FISCAL YEAR 1999

JUNE GIBBS BROWN
Inspector General

FEBRUARY 2000
A-17-00-00500

ERNST & YOUNG

Ernst & Young LLP
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Washington, D.C. 20036

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Report of Independent Auditors

To the Inspector General of the
Department of Health and Human Services, and
the Administrator of the Health Care Financing Administration

We have audited the consolidated balance sheet of the Health Care Financing Administration (HCFA), an operating division of the Department of Health and Human Services as of September 30, 1999, and the related consolidating statements of net costs and changes in net position and the combined statements of budgetary resources, and financing for the fiscal year then ended. These financial statements are the responsibility of HCFA's management. Our responsibility is to express an opinion on these financial statements based on our audit. The Medicaid Program, a major HCFA administered program, had total assets of $12 billion as of September 30, 1999, and total net costs of $109 billion for the year then ended. The Medicaid Program financial information, which is included in HCFA's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion, insofar as it relates to Medicaid financial information, is based solely on the report of other auditors.

We conducted our audit for the year ended September 30, 1999, in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States and Office of Management and Budget Bulletin 98-08, *Audit Requirements for Federal Financial Statements*, as amended. These standards and requirements require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, based upon our audit and the report of other auditors, the financial statements referred to above present fairly, in all material respects, the financial position of the HCFA at September 30, 1999, and its net costs, changes in net position, budgetary resources, and reconciliation of net costs to budgetary obligations for the fiscal year then ended, in conformity with generally accepted accounting principles.

Our audit was conducted for the purpose of forming an opinion on the financial statements referred to in the first paragraph. The information in the Overview of HCFA and the Supplemental Information of the HCFA is not a required part of the financial statements, but is supplementary information required by Office of Management and Budget Bulletin 97-01, *Form and Content of Agency Financial Statements*. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated financial statements, and accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our reports dated February 1, 2000, on our consideration of the HCFA's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations. These reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

Ernst & Young LLP

February 1, 2000

ERNST & YOUNG

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Washington, D.C. 20036

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Report of Independent Auditors on Internal Control

To the Inspector General of the
Department of Health and Human Services, and
the Administrator of the Health Care Financing Administration

We have audited the consolidated balance sheet of the Health Care Financing Administration (HCFA) as of September 30, 1999, and the related consolidating statements of net costs and changes in net position and the combined statements of budgetary resources, and financing for the fiscal year then ended, and have issued our report thereon dated February 1, 2000. The Medicaid Program, a major HCFA administered program, had total assets of $12 billion as of September 30, 1999, and total net costs of $109 billion for the year then ended. The Medicaid Program financial information, which is included in HCFA's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion and the comments reflected herein, insofar as they relate to Medicaid financial information, are based solely on the report of other auditors.

We conducted our audit in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and, Office of Management and Budget (OMB) Bulletin 98-08, *Audit Requirements for Federal Financial Statements*, as amended.

In planning and performing our audit, we considered HCFA's internal control over financial reporting by obtaining an understanding of the agency's internal control, determined whether this internal control had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin 98-08. We did not test all internal control relevant to operating objectives as broadly defined by the Federal Managers Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.

The management of HCFA is responsible for establishing and maintaining internal control. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs on internal control policies and procedures. The objectives of internal control are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in

conformity with generally accepted accounting principles; and data that support reported performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information. Because of inherent limitations in any internal control, errors, and irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of internal control to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of the internal control that, in our judgment, could adversely affect the agency's ability to record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low levels the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. However, we noted certain matters discussed in the following paragraphs involving the internal control and its operation that we consider to be reportable conditions. The first three such matters noted below we consider to be material weaknesses.

MATERIAL WEAKNESSES

Financial Analysis and Central Office Oversight (Repeat Condition)

Although the HCFA central office maintains the financial accounting system, produces accounting policies and procedures, and prepares financial statements, HCFA's overall accounting structure is decentralized in that many day-to-day decisions, processing of transactions, and reconciliations between subsidiary files and supporting documentation are performed at the contractors. As a result, integrated financial systems and a sufficient number of properly trained personnel are required to perform periodic analyses and reconciliations to detect errors and irregularities in a timely manner.

HCFA implemented many improvements in FY 1999, including:

- the preparation of interim financial statements
- implementation of FACTS II for reporting budgetary information to Treasury
- inclusion of entries related to investment activities in the consolidating trial balance
- an improved process for supporting the roll-up of financial activities to the financial statements

However, significant financial management issues continue to impair HCFA's ability to accumulate, analyze, and distribute reliable financial information. Given the severity of these issues, and recognizing limited resources as well as system and process limitations, it will take a sustained commitment and further additions to HCFA financial management and analysis staff and enhanced protocols to achieve further improvement in HCFA financial management.

Financial Reporting - HCFA Central Office

Although improvements were noted in the accumulation of financial information in preparation of financial reporting, HCFA did not perform sufficiently detailed periodic analyses of information supporting financial statement balances. The following represents specific areas we noted that need enhanced periodic reconciliation and analysis procedures to ensure material misstatements are identified in a timely manner.

- HCFA did not perform adequate analyses of accounts receivable, revenues, and expenditures to ensure an understanding of why fluctuations took place within balances and to ensure that balances within the general ledger were accurate and reasonable.
- HCFA is responsible for the administering of funds within the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds, held at the Bureau of Public Debt. During FY 1999, internal control related to fund balance with treasury, investment, and financial reporting were inadequate to timely identify errors in the SMI and HI trust funds, including an over-funding and under-funding of $18 billion and $14 billion, respectively. Additionally, as a result of these errors, the trust funds did not receive the appropriate interest incurring, which is an understatement of approximately $237 million in the SMI trust fund and overstatement of $154 million on the HI trust fund. There were several factors contributing to the series of errors that include:

    - Investment balances reported by the Bureau of Public Debt to HCFA are not independently verified by HCFA to ensure the accuracy of investments, interest income, and interest receivable transactions.
    - Controls related to supervisory reviews of reconciliations and interim financial statements were inadequate and were not performed at a sufficiently detailed level by individuals with the background needed to recognize that balances were inappropriate.

- Processes used to calculate the estimated draw down allocations and the month end adjustments to the trust funds were not effective in ensuring transfer activities were accurate.

HCFA, in coordination with the Department of Health and Human Services (DHHS), is currently working with the Department of Treasury to resolve the various issues and considering appropriate measures that will be needed to properly credit interest to each trust fund. Although aggregate fund balances with treasury and investment balances were properly stated in HCFA's FY 1999 financial statements, cash transfers relating to the principal to make the trust funds whole were not recorded until October 1999. Issues relating to interest may require legislative relief to restore the trust funds for the amounts, which would have been reflected, had such errors not occurred.

- Our review of reconciliations between Treasury and HCFA's fund balance with Treasury records noted certain reconciliations had not been performed timely, stale differences had not been resolved, and supervisory reviews had not been documented.
- Through its calculation of Entitlement Benefits Due and Payable during November 1999, HCFA noted that the National Claims History file did not contain approximately 100 million claims, amounting to over $13 billion related as far back as June 1999.
- Although progress was made in the preparation of its financial statements, HCFA needs to streamline and document its processes to effectively accumulate, assemble, and analyze information to timely develop its financial statements on a routine and recurring basis. For example, HCFA was unable to prepare an initial draft of its financial statements for September 30, 1999 until December 7, 1999 and with refinements to disclosure requirements continuing until January 2000. Additionally, as of January 2000, entries identified in the preparation of financial statements had not been recorded to the general ledger. Factors contributing to this short fall include lack of an integrated financial system, untimely preparation of reconciliations, limited communication between branches, and limited personnel resources.

Financial Reporting and Reconciliations - Medicare Contractors

The OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. HCFA does not have an integrated accounting system to capture expenditures at the Medicare contractor level. HCFA relies on a complex system of reporting and ad hoc reports to accumulate data for financial reporting.

Our review of the internal control at selected Medicare contractors disclosed numerous weaknesses in their abilities to report accurate financial information. These weaknesses may be partly due to the absence of certain components of a fully integrated financial management system; that such absences include full accrual accounting, a double-entry general ledger system, proper cut-off procedures, and adequate source documentation for Medicare Program activity. These weaknesses increase the risk of material misstatement in the financial statements. In addition, Medicare contractors do not utilize uniform accounting systems that record, classify, and summarize information for the preparation of financial statements. Additionally, as discussed below, HCFA's central office and regional office oversight of Medicare contractor operations and financial management controls has not provided reasonable assurance that material errors would be detected in a timely manner.

The reconciliation of "total funds expended" on the HCFA 1522, Monthly Contractor Financial Report is an important control that ensures all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. At the Medicare contractor level, "total funds expended" is the sum of all checks drawn and electronic fund transfer payments issued during the calendar month less voided checks and overpayment recoveries. This amount is then further classified by component into the following categories: benefit payments, PIP, accelerated payments, net suspense payments, audit reimbursement adjustments, and interest income and expenses. HCFA uses certain information from this report to prepare its financial statements.

An essential part of the audit is a review of paid claims to determine if claims are paid in accordance with Medicare regulations and are for covered services. The reconciliation is critical because the auditors must be able to obtain a file of paid claims that will reconcile to the HCFA 1522 before selection of a statistically valid sample of claims is reviewed. We noted certain issues on how Medicare contractors prepared the HCFA 1522. Our analysis of the HCFA 1522 reports at eight selected Medicare contractors identified the following similar internal control weaknesses as reported in our prior audit reports.

- Five contractors did not formally reconcile paid claims activity to "total funds expended" on a monthly basis.
- One contractor did not have internal policies or procedures for preparing the HCFA 1522. Specifically, the contractor did not establish procedures to (1) reconcile the outstanding check amount per the general ledger to the bank statement outstanding check amount; (2) void outstanding checks over 180 days old; (3) reconcile the bank account to the cash receipt logs; and (4) allocate manual activity to the various total funds expended components. Additionally, the contractor failed to correct misclassification errors that had occurred as a result of a recent system conversions.

- While three contractors did have readily available general ledger and appropriate subsidiary records to support all components of "total funds expended" on the HCFA-1522, we noted that a fully integrated reporting system was not in place at any of the 8 contractors. The five contractors who did not have a general ledger had to obtain data to prepare the HCFA-1522 from various sources, such as computerized claims processing systems, bank statements, manually prepared documents and ledgers, and estimates.
- One contractor's HCFA-1522 was not subject to independent verification.

Recommendations

We recommend that HCFA strengthens controls to improve the reliability and documentation of its financial information and to strengthen oversight to including:

- Develop high level and as appropriate exception driven analysis techniques within HCFA central office and regional offices to obtain reports from contractors each month, array the reported information in a method that facilitates comparisons month to month, year to year against actual and budgeted amounts and between contractors and against HCFA management's expectations to identify and follow-up on emerging trends and anomalies in reported results.
- Develop policies and procedures to monitor and verify balances reflected in consolidated periodic reports, including balances reflected in the investments, interest receivable, and interest revenue accounts. Perform and oversee monthly reconciliations and develop supporting documentation that reflects management's understanding of the composition of the accounts. Provide the information necessary to allow successive layers of managers working with the data to understand what has been done to ensure that their decisions based upon has been challenged and reviewed for consistency with expected relationships.
- Ensure that all Medicare contractors develop control procedures to provide independent checks of the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with contractors' supporting documentation, and periodically review contractors' control procedures over reconciliations to ensure that required accounting reports, subsidiary ledgers, and adequate documentation are available on a timely basis to support the financial statement reporting requirements.
- Develop procedures to ensure an audit trail exists and approval of entries and assumptions are made for transactions at the Medicare contractors and HCFA central office.
- Continue efforts to promote uniformity and integration of Medicare contractors' systems.

- Develop procedures to provide a mechanism for HCFA central office and regional offices to monitor contractors' activities and enforce compliance with HCFA financial management procedures. This may include obtaining detailed subsidiary ledgers from contractors to the HCFA central office, reviewing subsidiary ledgers for reasonableness, obtaining query access to financial systems to identify and investigate unusual items, and reviewing reconciliations prepared by the contractors.
- Provide additional training for financial personnel at the HCFA central office, the regional offices, and for the Medicare contractors to ensure that financial personnel understand the importance of posting entries correctly, performing account analyses and reconciliations, maintaining supporting documentation, and updating their knowledge of financial reporting requirements.

Medicare Accounts Receivable *(Repeat Condition)*

For the year ended September 30, 1999, HCFA reported a net accounts receivable balance of $4.2 billion, comprised of gross outstanding accounts receivable of $7.3 billion and an aggregate allowance for uncollectible accounts of $3.1 billion. Medicare accounts receivable primarily represent funds owed by providers to HCFA due to overpayments, as well as funds due from other entities in instances that Medicare is the secondary payer (MSP) of claims. HCFA's contractors are responsible for reporting and collecting the majority of these receivables (over 81 percent of the outstanding balance at year-end). HCFA's central office and regional offices manage the remaining balance.

HCFA developed a detailed corrective action plan to improve its accountability of its accounts receivable related accounts in FY 1999. Although the plan was not fully implemented by September 30, 1999, we noted certain improvements as follows:

- Developed Excel/ad hoc programs to maintain subsidiary ledgers which provide detailed information to support accounts receivable related balances.
- Performed a study of accounts receivable at an interim date, emphasizing the importance that contractors maintain support for reported balances.
- Implemented formalized policies and procedures for the write-off of uncollectible accounts receivables.
- Implemented controls to ensure proper supervisory review of transactions.
- Improved the timeliness of interim rate reviews.
- Developed and provided additional training to contractors, regional office, and central office personnel in the area of accumulation and verification of accounts receivable related balance.

While progress was made, significant financial management issues are still affecting HCFA's ability to accumulate and analyze its financial activities related to Medicare accounts receivable.

During our review of the accounts receivable balances, we noted that the receivable balances are not routinely analyzed or monitored by HCFA's central or regional offices other than on a very aggregated basis; a level at which limited analysis can be performed at HCFA in light of the different types of accounts receivable generated and the decentralized nature of processing activity. Specifically, since the central office does not perform a routine detailed review or analysis of contractors' submitted information, HCFA has limited assurance whether account balances are accurate or supported by the appropriate documentation; and is not well positioned to identify emerging trends in accounts receivable activities which may require additional management attention.

Additionally, HCFA cannot readily isolate or identify activities in accounts receivable that could have a material impact on the financial statements. For example, HCFA did not perform a detailed analysis throughout FY 1999 to gauge the effect of providers transitioning to the interim payment and the prospective payment systems. In conjunction with full implementation of certain provisions of BBA 97, one contractor's activity ultimately resulted in increases in accounts receivable collectively exceeding $1 billion. In some cases, however, these accounts receivable are associated with providers who are now insolvent, have withdrawn from the Medicare programs, and/or ceased operations or in some cases have negotiated extended repayment plans. Two key factors contributing include the lack of sufficient resources at HCFA central and regional offices; and procedures that do not require HCFA central office to obtain detailed information to perform a detailed review of accounts receivable balances and transactions by contractor, type of receivable and as appropriate by provider.

Further, HCFA reported an allowance for doubtful accounts totaling $2.2 billion at September 30, 1999, related to Medicare contractor non-MSP accounts receivable. The Medicare Contractors and the central office are using the HCFA protocol to calculate and record the allowance for doubtful accounts. During FY 1999, HCFA central office implemented new procedures in calculating the allowance; however, the Medicare contractors and the central office did not test their allowance calculation for reasonableness. In addition, HCFA did not initially and explicitly adjust its allowance process to reflect the probability that some of the accounts receivable associated with bankrupt skilled nursing facilities, home health agencies, and other providers (which have either experienced financial difficulties, withdrawn from the Medicare programs, and/or ceased operations) that may not pay their accounts when due, with or without extended payment plans. For example, in our analysis of all accounts receivable greater than $1 million for 12 contractors, we noted that only $125 million of $961 million or 13% were collected in the first quarter of FY 2000 and that $648 million or 67% were unlikely to be recovered due to providers being terminated, bankrupt, or unlikely to pay. Once provided to HCFA, additional analysis was required to determine the adequacy of the allowance.

Consistent with prior years, our audit procedures at eight Medicare contractors indicated that controls in aggregate at the contractor locations continue to need improvement. The Medicare contractors lack a formal integrated accounting system to accumulate and report financial information. Additionally, although improved from FY 1998, the contractors are using Ad-hoc (Excel and Lotus spreadsheets) reports, which are very labor intensive to develop and supplement financial information reported to HCFA central office. Finally, due to the volume of transactions processed by contractors, there is insufficient time available to thoroughly review financial data prior to submission to the central office.

Non-MSP Accounts Receivable

Medicare contractors managed approximately $5.6 billion of gross Non-MSP accounts receivable at September 30, 1999. At year-end, the eight contractors in our sample managed gross Non-MSP accounts receivable of approximately $1.8 billion. Overall, the Medicare contractors have made significant improvements in maintaining supporting records for Non-MSP related activities and year-end balances. However, we found that independent verification controls were not established or were not consistently applied to provide reasonable assurance that amounts reported by contractors to HCFA were valid, accurately summarized and sufficiently documented. Some of the deficiencies noted in accounting for Non-MSP activities during FY 1999 are presented below:

- One contractor recorded a liability incorrectly to an accounts receivable account that resulted in an understatement of $130 million.
- Three contractors had bank reconciliations that were not reviewed by a supervisor.
- One contractor has $5.4 million in unresolved letter of credit draws.
- Two contractors had undocumented supervisory review of certain rate calculations.
- One contractor overstated receivable balances by $58 million because it did not account for all claims and payment activities.

Additionally, although HCFA took significant measures in implementing a Non-MSP write-off policy, controls surrounding the execution of the write-off of stale-dated and unsupported accounts receivable should have been enhanced through improved monitoring by HCFA central offices. We noted certain amounts approved by the HCFA central office did not agree with the amounts subsequently written off with differences not being properly tracked.

Lack of Integrated Financial Management System for Accounts Receivable and Claims Activity

OMB Circular A-127, *Financial Management Systems*, requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair HCFA's and the Medicare contractors' abilities to adequately support the accounts receivable activities and balances reported.

Certain Medicare contractors' claims processing systems do not have general ledger capabilities. Accounts receivable balances reported by the contractors are generally maintained on personal computer (PC) based software. The claims processing systems lack the capability to properly classify, summarize, and report Medicare transactions in accordance with the requirements of OMB A-127.

Recommendations

We recommend that HCFA continues to reengineer its processes to improve its monitoring, analysis, and tracking of accounts receivable. Specifically, we recommend that the following procedures be implemented:

- Provide additional guidance and training to Medicare contractors to promote a uniform method for reporting and accounting for accounts receivable and related amounts.
- Review and monitor the accounts receivable internal control to provide reasonable assurance that reported amounts and transactions are valid and documented.
- Establish an integrated financial management system for use by Medicare contractors and HCFA's central office to promote consistency and reliability in recording and reporting accounts receivable information.
- Ensure that all Medicare contractors develop control procedures to provide independent checks of the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation, and periodically review contractors' control procedures over the reconciliation.
- Develop appropriate input/output controls for routinely reviewing and documenting the HCFA reports received from Medicare contractors in order to timely identify unusual items and inconsistencies and to emphasize HCFA's reliance on these reports. With respect to output controls, we suggest that at a minimum, HCFA obtain detailed accounts receivable information by major type and contractor, arrayed by provider for the largest such accounts, and implement a monthly review at central office; augmented by regional resources as necessary to investigate items of note from the contractors.

- Revise reporting requirements to reflect HCFA's expectation of the need to retain supports for significant accounts, in an auditable format, at each Medicare contractor site.
- Periodically reassess the accounts receivable reserve estimate, and explicitly adjust the estimate for individual accounts receivable above a threshold amount which merit case by case reserving methods.

Medicare Electronic Data Processing (EDP) Controls (Repeat Condition)

To effectively and efficiently control and administer the Medicare program and process and account for more than $200 billion in federal Medicare expenditures in FY 1999, HCFA continued to rely on significant data processing operations at both HCFA's central offices and various contractors to process Medicare claims and maintain eligibility systems. HCFA's central office data center maintains administrative information such as Medicare enrollment, eligibility, and paid claims history information. The HCFA central office also processes all payments for Medicare managed care.

For consistency in the payment of Medicare fee-for-service claims, Medicare contractors use one of several "shared" systems. As a component of processing fee-for-service claims, the "shared" systems interface with the Common Working File (CWF) to obtain authorization to pay submitted claims. The CWF consists of seven distributed databases maintained throughout the United States by contractors referred to as CWF hosts. The CWF is used to coordinate Medicare Part A and Part B benefits and approve claims for payment. The "shared" and CWF systems are designed and maintained by certain contractors referred to as systems maintainers.

Our review of the EDP internal controls was limited to general data processing and application controls and did not include management or operational controls. General data processing controls, also referred to as "general controls", are critical to ensuring the integrity, confidentiality, and availability of HCFA's Medicare data that is processed by HCFA's central office and contractors. General control objectives are defined for six categories: entity-wide security, access control, application development and program change controls, segregation of duties, operating systems software, and service continuity. The EDP general controls impact the integrity of all applications that are operated within a single data processing facility.

We found numerous EDP general control weaknesses at the HCFA central office and the Medicare contractors, as well as application control weaknesses at the contractors' shared systems. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, or (4) disruption of critical operations. Further, weaknesses in HCFA's entity-wide security structure do not ensure that EDP controls are adequate and operating effectively. Overall, the weaknesses in the EDP systems environment include some that have been identified as material.

In FY 1999, EDP control weaknesses were identified at seven Medicare contractors and the HCFA central office for which full-scope general control reviews were performed and of which three were subject to application review procedures. Additional weaknesses were identified as a result of application change control review procedures performed in fiscal 1999 for three Medicare systems maintainers. For these reviews, specific reportable conditions were identified in entity-wide security programs, access controls, application development and program change controls, segregation of duties, operating systems software controls and service continuity. Follow-up review procedures were performed during FY 1999 for four Medicare contractors for which full-scope general and application reviews were performed during FY 1998. Our follow-up reviews in Fiscal 1999 on full-scope reviews performed in Fiscal 1998 indicated that progress had been made to appropriately resolve many of the prior year findings.

Because certain reconciliation and report review processes within HCFA are still evolving and require further improvement as noted in this report on internal control, the general and application controls are critically important to HCFA to ensure the integrity, confidentiality, and availability of sensitive Medicare data.

Medicare Contractors

We completed general EDP control reviews at a sample of seven Medicare contractors in FY 1999. In addition, application change control reviews were performed at three CWF and MCS system maintainer sites. Further, the application controls of the Viable Information Processing System (VIPS), the Multi-Carrier system (MCS), and the CWF were assessed.

We identified opportunities for enhancing information systems controls at each of the seven Medicare contractors we reviewed. Specifically, we found that entity-wide security procedures, access controls, segregation of duties, operating systems software controls, and service continuity procedures needed to be enhanced at the seven contractors.

We found that the material weakness noted in the previous fiscal years related to the Fiscal Intermediary Shared System (FISS) remains unchanged. We previously reported that Medicare data centers had access to the source code of the Fiscal Intermediary Shared System (FISS) and are able to implement local changes to FISS programs. Such access may be abused resulting in unauthorized programs that are implemented and processed at fiscal intermediaries and carrier data centers. While HCFA requires contractors to restrict local changes to emergency situations, such local changes are not subjected to the same controls that exist in the standard FISS change control process. This prior year material weakness remains open.

For the Multi-Carrier System (MCS), we previously reported as a material weakness that each individual carrier could deactivate HCFA mandated edits. The relevant changes were implemented during FY 1998 through system changes and the material control weakness was considered resolved for FY 1999.

HCFA Central Office Computer Facility

For the FY 1999 central office review, we updated the status of prior year findings and also performed review procedures in the six general control areas described above. We determined that HCFA's central office has initiated the implementation of enhanced control procedures, specifically in access controls and application development and program change controls but these efforts were incomplete as of the end of FY 1999.

Significant control enhancements being implemented include:

- Planning for additional security software to appropriately restrict access to sensitive Medicare databases at the central office
- Migration to enterprise-wide program change management software, with full implementation planned for FY 2001

- Issuance of task orders to various contractors to address issues related to risk assessment, security policies and procedures, independent verification and validation procedures for the central office networks, and the development of entity-wide security plans and related procedures for significant systems.

However, HCFA's central office continued to expend significant resources to address Year 2000 readiness issues during FY 1999, therefore not all prior year findings were addressed. Additional findings for FY 1999 were identified in the areas of entity-wide security and operating systems software controls. For FY 1999, prior year findings from the previous two fiscal years for both general controls and application controls were combined into a total of twelve reportable conditions and one material control weakness.

HCFA should continue its focus on implementing appropriate corrective action plans in resolving all findings to improve the controls over integrity, confidentiality, and availability of Medicare data processed at the central office.

Recommendations

HCFA continues to rely heavily upon automated systems processed by more than fifty Medicare contractors for the consistent administration of virtually all aspects of the program. Accordingly, based on the significance of the weaknesses identified as a result of the FY 1999 review procedures at both the selected Medicare contractors reviewed and HCFA's central office, the needed improvements are considered to be material weaknesses. Detailed findings and recommendations for each full-scope review and follow-up review have been communicated to OIG and HCFA management.

Central Office

HCFA management should continue to implement cost-effective control improvements for the central office to include:

- Entity wide security programs for all significant production applications and related users.

- Adequate, monitored, and enforceable general computer access controls to restrict sensitive data and other resources from unauthorized usage, modification, or destruction.

- Implementation of entity-wide consistent change control procedures for all significant production applications and systems software programs.

- Improved segregation of duties to include appropriate assignment of responsibilities.

- Implementation of software selected by the HCFA central office to mitigate risks as identified by the material control weakness related to production database software access control limitations.

Medicare Contractors and System Maintainers

HCFA management should, in conjunction with the Medicare contractors and system maintainers that support the overall development, maintenance, and processing of the Medicare system, continue to develop, implement, and monitor cost-effective controls to include:

- Consistent adherence to OMB A-130 guidelines for entity-wide security plans to ensure appropriate consideration is given to safeguarding Medicare data.
- Consistent and effective physical and logical access procedures, including administration and monitoring of access by Medicare contractor personnel in the course of their job responsibilities.
- Consistent and effective procedures over the implementation, maintenance, access, and documentation of operating systems software products used to process Medicare data. Appropriately controlled operating systems software products are fundamental to the integrity of processing of Medicare data.
- Attention to appropriate segregation of duties to ensure accountability and responsibility for access to Medicare applications and data are appropriately assigned.
- Updating and appropriately documenting service continuity procedures to recover Medicare processing in the event of a system outage.

REPORTABLE CONDITIONS

HCFA Regional Office Oversight of Medicare (Repeat Condition)

HCFA's regional offices have oversight responsibility for Medicare contractors. A majority of the oversight efforts is conducted through the Contractor Performance Evaluation (CPE) review process. The purpose of CPE is to evaluate Medicare contractors' compliance with Medicare laws and regulations.

Contractors administer claims paid to providers, perform program safeguards activities, and prepare and submit periodic financial reports to HCFA that are used in the preparation of HCFA's financial statements. During 1999 and early 2000 HCFA implemented or began the implementation of several initiatives which should enhance oversight of Medicare contractors, including use of independent contractors to perform reviews of more than 20 of the major contractors' systems and processes and reviews of Audits of Quality Review Procedures (AQRPs). Continued efforts are underway to implement initiatives to engage payment safeguard contractors.

Throughout this process, while we noted continued improvement in many of the Medicare oversight procedures performed by the regional offices, including OIG investigations initiated throughout the system, we found that certain procedures were not adequate or were not being performed consistently in all regions to ensure that financial data provided by contractors is reliable, accurate, and complete.

- Contractor assessments, including CPEs, and on-site reviews of STAR data and MSP operations do not provide sufficient coverage of contractor operations.
- Inadequate procedures to ensure the appropriate tracking of contractor responses to CPE reports.
- Insufficient procedures for quarterly analysis of Medicare contractors' Statements of Financial Position (HCFA 750) and Status of Accounts Receivable (HCFA 751) reports.
- Insufficient procedures for monthly analysis of HCFA 1522 reports.
- Inadequate procedures to evaluate the accuracy of the contractor's self-assessment certifications.
- Lack of oversight procedures to verify completeness of the Provider Overpayment Report (POR) and the Physician Supplier Overpayment Report (PSOR)
- Lack of supervisory reviews related to some CPEs.
- Inconsistent documentation of risk assessment procedures used to allocate resources to reviews

Recommendations

The following recommendations would greatly enhance the regional offices' oversight functions:

- Expand application of current assessment and on-site review procedures to provide the appropriate coverage of contractor operations.
- Enhance controls to ensure the appropriate tracking of contractor responses to CPE reports.
- Provide additional instruction, guidance and training to communicate expectations and the procedures to be performed by regional offices to ensure that HCFA 750/751 and HCFA 1522 reports are submitted timely and are properly reconciled to accounting records.
- Develop and utilize a review protocol to directly evaluate the reliability of the contractors' self-assessment of their internal controls.
- Ensure that Provider Overpayment Recovery and Physician Supplier Overpayment Recovery data are accurate, valid and complete for all Medicare contractors.
- Enhance controls to ensure the appropriate level of supervisory review related to CPE's
- Ensure that all regional offices are utilizing and documenting risk assessments to allocate resources to reviews

Medicare Entitlement Benefits Due and Payable (Repeat Condition)

Medicare entitlement benefits due and payable totaled approximately $24 billion at September 30, 1999. These liabilities represent the cost of services provided to Medicare beneficiaries but not paid at the end of the fiscal year. As first noted in the FY 1997 audit, data reliability concerns were again identified in FY 1999. Significant strides were made by HCFA in analyzing the data produced and critically assessing results obtained, including implementing more formalized approaches to finalizing the estimate and documenting conclusions. However, current procedures may not be adequate to detect errors in data used in future projections. Specifically, we noted the followings:

- Although HCFA had established procedures for validating and reviewing source data and estimates used in the preparation of the overall entitlement benefits due and payable estimate, additional enhancements are necessary to ensure reliability of the estimate.
- Differences were noted between claims on the payment floor, outstanding checks, and periodic interim payment amounts reported by the contractor to HCFA and supporting documentation maintained at the contractors.
- STAR data, which is HCFA's primary source for cost settlement information, is inconsistent with cost settlement information that recorded on the HCFA 1522 reports prepared by the contractors. Consequently, STAR data is adjusted to reconcile to balances included on HCFA 1522 which is considered by HCFA to be more reliable.

Recommendations

We recommend that:

- Policies and procedures be strengthened to ensure that the National Claims History file is complete and accurate, and that processes implemented in FY 1999 which ensure that input to the incurred but not reported claim estimation model agrees with data in the general ledger, HCFA financial statements, and the changes in the national claims history file be made a standard protocol.
- Guidance be provided to contractors to emphasize the need for accurate reporting of requested data. Further, procedures should be enhanced to validate contractor provided data, including requesting copies of report runs on a test basis as appropriate, and critically assess the appropriateness of the estimates provided and document management's conclusion.
- HCFA assess the feasibility of modifying STAR data to accurately reflect cost settlement activities, adding necessary information on the date that a cost settlement is finalized, and when it is paid.

Medicaid Claims Estimated Improper Payments (Repeat Condition)

No methodology currently exists for estimating the range of improper Medicaid payments on a national level. The OIG has been reviewing a statistically valid sample of Medicare claims for the last several years and has determined an estimated range of improper payments out of the total fee-for-service payments processed by HCFA. The majority of the errors fell into four broad categories: insufficient or no documentation, lack of medical necessity, non-covered or unallowable service, and incorrect coding. The results of this sampling provide HCFA with useful information in helping HCFA to reduce the overall Medicare improper payments. With no similar methodology in place for the Medicaid Program, HCFA is unable to draw any conclusions at a national level on improper Medicaid payments. Since Medicaid is a grant program, any sampling would need to be done in conjunction with the states.

Recommendations

The other auditors recommended in our prior report that HCFA worked with the states to develop procedures for the implementation of a methodology to determine the range of improper payments in the Medicaid Program.

DHHS has established a departmental work group, as the purpose of which would be to review the issue of Medicaid error rates. Additionally, we recommend that the work group discussions begin on development of a methodology that could be implemented in all the states on a consistent basis.

* * * * * * * *

In addition, with respect to internal control related to performance measures reported in the Overview, we obtained an understanding of the design of significant internal control relating to the existence and completeness assertions, as required by OMB Bulletin 98-08. Our procedures were not designed to provide assurance on internal control over reported performance measures, and, accordingly, we do not provide an opinion on such controls.

A separate letter, dated February 1, 2000, was provided to management that further discusses weaknesses in internal control and other matters which came to our attention as a result of our audit.

This letter is intended solely for the information and use of the management of HCFA and the OIG, the DHHS, the OMB, and the Congress; and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

February 1, 2000

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Report of Independent Auditors on Compliance with Laws and Regulations

To the Inspector General of the
Department of Health and Human Services, and
the Administrator of the Health Care Financing Administration

We have audited the consolidated balance sheet of the Health Care Financing Administration (HCFA) as of September 30, 1999, and the related consolidating statements of net costs and changes in net position, and combined statements of budgetary resources, and financing for the fiscal year then ended, and have issued our report thereon dated February 1, 2000. The Medicaid Program, a major HCFA administered program, had total assets of $12 billion as of September 30, 1999, and total net costs of $109 billion for the year then ended. The Medicaid Program financial information, which is included in HCFA's consolidated and combined financial statements, was audited by other auditors whose report has been furnished to us, and our opinion and the comments herein as they relate to Medicaid financial information, are based solely on the report of other auditors.

We conducted our audit in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 98-08, *Audit Requirements for Federal Financial Statements*, as amended.

The management of HCFA is responsible for complying with laws and regulations applicable to the HCFA. As part of obtaining reasonable assurance about whether the HCFA's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin 98-08, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996. We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to HCFA. We caution that noncompliance may occur and not be detected by the tests performed and that such testing may not be sufficient for other purposes.

The results of our tests of compliance with laws and regulations described in the preceding paragraph, exclusive of FFMIA, disclosed no instances of noncompliance with other laws and regulations that are required to be reported under *Government Auditing Standards* and OMB Bulletin 98-08.

Under FFMIA, we are required to report whether HCFA's financial management systems substantially comply with the Federal financial management systems requirements, applicable accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance using the implementation guidance for the FFMIA included in Appendix D of OMB Bulletin 98-08.

The results of our tests disclosed instances in which the HCFA's financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph. We have identified the following instances of noncompliance.

- HCFA does not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the existing financial reporting system does not conform to the requirements currently specified by the Joint Financial Management Improvement Program.

- HCFA's central office and Medicare contractor access and application control weaknesses are significant departures from requirements specified in OMB Circulars, A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

As reported by HCFA in Footnote 9 to the financial statements referenced above, certain claims submitted by providers do not comply with Medicare laws and regulations.

The Report of Independent Auditors on Internal Control and our separate management letter includes information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented, and that relevant comments from HCFA's management responsible for addressing the noncompliance, including management's proposed action plan, which is provided as an attachment to this report.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.

This report is intended solely for the information and use of the management of HCFA, the Office of the Inspector General, the Department of Health and Human Services, the OMB, and the Congress; and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

February 1, 2000

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

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This letter is in response to your audit report on the Health Care Financing Administration's (HCFA's) fiscal year (FY) 1999 financial statements. Your report identifies three material weaknesses: 1) Financial Analysis and Central Office Oversight, 2) Medicare Accounts Receivable, and 3) Medicare Electronic Data Processing (EDP) controls. Each of these weaknesses is repeated from the FY 1998 audit of HCFA's financial statements.

HCFA generally concurs with the findings and descriptions of weaknesses. As noted in your report, HCFA has made many improvements in these areas during FY 1999. Specifically, in the area of financial management, we prepared interim financial statements and have automated our process for developing the financial statements. Additionally, the Medicare contractors have developed subsidiary ledgers that provide the detailed information to support accounts receivable related balances. We have implemented polices and procedures for the write-off of uncollectible accounts receivable, and have also provided training to personnel at contractor sites, the regional offices and central office regarding the accumulation and verification of accounts receivable balances.

A factor contributing to these repeated weaknesses is HCFA's lack of an integrated general ledger system that captures financial data at the contractor level. While we have developed and are implementing short term corrective actions to address these noted weaknesses, we anticipate that HCFA will be able to fully resolve them once our integrated general ledger system at the contractors is completed and fully operational.

As we continue to make significant progress in our efforts to address these weaknesses, we remain committed to our goal of providing reliable financial information regarding the operation of HCFA's programs. We will continue to track our progress and report it to the Department on a regular basis.

I would also like to thank your office for working so diligently with my staff to address the financial issues that arose during the course of the audit.

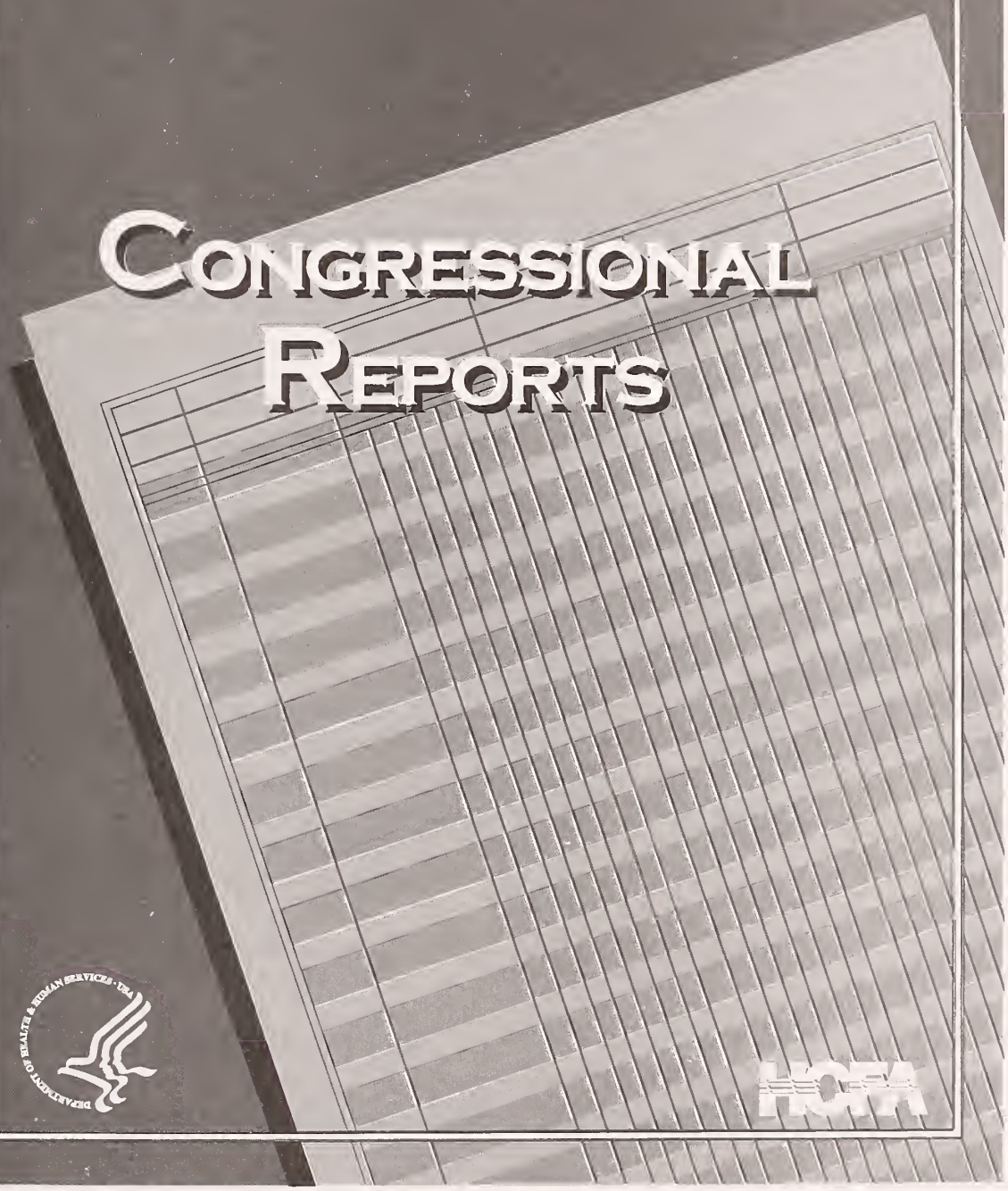
Sincerely,

A. Michelle Snyder
Chief Financial Officer

U.S. Department of Health and Human Services

Health Care Financing Administration

Congressional Reports



Congressional Reports

Medicare's Validation Program for Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 1998 Report

Introduction

Section 1865 of the Social Security Act (the Act) provides that JCAHO-accredited hospitals are deemed to meet the Medicare conditions of participation (CoPs). These hospitals are not subject to routine State surveys to assess compliance with the Medicare CoPs. Subsection 1864(c) of the Act, however, authorizes the Secretary to enter into an agreement with any State to survey hospitals accredited by the JCAHO on a selective sample basis or in response to allegations of significant deficiencies that affect the health and safety of patients. The Act further requires, at Section 1875, that the Secretary include an evaluation of the JCAHO accreditation process for hospitals in an annual report to Congress. This evaluation is referred to as the validation program.

The purpose of the validation program is to determine whether the JCAHO's accreditation process provides reasonable assurance that accredited hospitals comply with the statutory requirements at section 1861(e) of the Act for participation in the Medicare program as hospitals. Each year, the Health Care Financing Administration (HCFA) selects approximately 5 percent of the JCAHO-accredited hospitals to be surveyed. Effective in 1998, the selection process for hospitals to be included in the validation program was improved. The sampling methodology was changed from a six-month sampling process to a systematic year-round random sampling methodology. This change strengthened the validation of accredited hospitals by increasing the sample size from 79 hospitals in FY 1997 to 161 hospitals in FY 1998. A workgroup is developing criteria to further improve the hospital selection and evaluation methodology for validation of accreditation programs.

Sample validation surveys fall into three categories. They are:

1. Random sample (hospitals randomly selected for survey within 60 days after the JCAHO survey);
2. 18-month sample (hospitals randomly selected for survey at the midpoint of their 3-year JCAHO accreditation cycle); and
3. Conditional sample (hospitals surveyed for selective Medicare requirements, based on JCAHO findings that caused the JCAHO to render an accreditation decision of conditional).

The JCAHO accreditation survey assesses a hospital's compliance with the JCAHO's standards. After completion of the on-site survey, the JCAHO makes an accreditation decision. The accreditation decisions include: accreditation, accreditation with Type I recommendations, conditional accreditation, and no accreditation.[1] Accreditation means that the hospital meets all JCAHO standards and requirements. Accreditation with Type I recommendations means that the hospital is granted accreditation with the assurance that the identified recommendations for improvement are corrected. The JCAHO requires hospitals with Type I recommendations to submit a written progress report or undergo a followup survey. Conditional accreditation means that the hospital is in substantial noncompliance with JCAHO standards. Table 1 summarizes the JCAHO's accreditation decisions for Medicare-approved hospitals receiving a triennial survey in calendar years 1997 and 1998.

Table 1. JCAHO Accreditation Decisions, Medicare-Approved Hospitals Surveyed in 1997 and 1998

Accreditation Decisions	No. Hospitals in 1997 (Percent)	No. Hospitals in 1998 (Percent)
Accreditation	219 (14)	253 (15.3)
Accreditation With Type I Recommendations	1,308 (83.6)	1381 (83.4)
Conditional	6 (0.4)	20 (1.2)
Total Surveyed [2]	1564 (100)	1655 (100)

Validation Survey Findings

Table 2 presents the number of random, 18-month, and conditional validation surveys HCFA performed, along with the compliance determinations (i.e., if the results of a validation survey showed noncompliance with one or more CoPs, the hospital was 'out of compliance'). A hospital may have had deficiencies of a lesser severity (e.g., standard level) and still be considered in compliance. This table also includes a comparison of the compliance pattern

[1] JCAHO accreditation decisions also include commendation, preliminary nonaccreditation, and provisional accreditation. [HCFA does not recognize provisional accreditation for deeming.] The JCAHO considers all hospitals to be 'accredited' except those that are not accredited, including preliminary nonaccreditation. HCFA currently accepts the JCAHO definition of 'accredited' for deeming purposes.

[2] Categories do not sum to total because table does not include all accreditation categories.

between validation surveys of accredited hospitals and routine surveys of nonaccredited hospitals.

Table 2. Compliance Determinations of Validation and Nonaccredited Hospital Surveys, 1998			
Validation Type	No. Out of Compliance	Percent	Total
Random Validation	36	23	157
18-Month Validation	0	0	1 [3]
Conditional Validation	0	0	3 [3]
All Validations	36	22	161
Nonaccredited	11	6	184

Table 3 presents the percentage of JCAHO-accredited hospitals found out of compliance by category of validation survey for the years, 1995 through 1998.

Table 3. Percent of JCAHO Accredited Hospitals Out of Compliance by Category for Validation Survey Periods 1995 -1998				
Survey Type	1995	1996	1997	1998
Random	28	18	16	23
18-Month	10	31	100	NA [3]
Conditional	29	0	NA [3]	NA [3]

Deficiency data were analyzed for 20 of 21 Medicare hospital CoPs:[4]

Federal, State, and Local Laws		Services	
Governing Body	Nursing	Anesthesia	RespiratoryCare
Medical Staff	Pharmaceutical	Rehabilitative	Emergency
Infection Control	Laboratory	Food & Dietetic	Outpatient
Quality Assurance	Medical Records	Surgical	NuclearMedicine
Discharge Planning	Physical Environment	Radiologic	

The three general health and safety CoPs found out of compliance most frequently for the 161 validation surveys performed in 1998 are shown in Table 4. The three CoPs found out of

[3] Small or non-existent sample. One hospital was surveyed midway in its triennial accreditation cycle and it was in compliance with the CoPs. Three JCAHO conditionally accredited hospitals were selected for validation surveys in 1998 and they were in compliance with the CoPs.

[4] The CoP not analyzed was Utilization Review. Accredited hospitals do not receive deemed status for this CoP.

compliance most frequently for the 184 nonaccredited hospitals surveyed in 1998 are shown for comparison.

Table 4. Most Frequently Cited Conditions of Participation During Surveys, 1998

Accredited Hospitals		Frequency		Nonaccredited Hospitals	Frequency
1	Physical Environment Life Safety Code	27	1	Quality Assurance	16
2	Quality Assurance	5	2	Infection Control	15
3	Medical Records	4	3	Physical Environment	8

JCAHO Survey Process for Life Safety Code (LSC)

Since 1995, the JCAHO has been evaluating hospital compliance with LSC by having the hospital assess its own compliance and record the findings and plans for correction on the JCAHO Statement of Conditions (SoC) document. If a JCAHO surveyor identifies a LSC deficiency that has not been self-reported on the SoC by the hospital, it is 'scored' (i.e., it becomes a recommendation on the accreditation report). A self-assessed deficiency is not scored and reported on the Accreditation Report unless the surveyor determines that the hospital is making little or no progress in correcting that deficiency. HCFA surveys do not include a self-assessment by the hospital. Any deficiencies noted by State surveyors are included on the Federal Form HCFA-2567, Statement of Deficiencies and Plan of Correction. Although taken into account in this report, at the present time comparison of specific LSC deficiencies found using the JCAHO self-assessment and the HCFA survey process is difficult. Another difficulty in comparing the two survey standards and processes is the differences in the two editions of the LSC used by HCFA (1985 edition) and the JCAHO (1997 edition) and the reporting forms used by each. Revisions to language in the later edition of the LSC (1997) do not allow for the development of an easily used crosswalk between the two survey processes at this time.

Allegation Surveys

In addition to the validation surveys, HCFA conducts substantial allegation (complaint) surveys of JCAHO-accredited hospitals in response to incoming complaints involving potential threats to the health and safety of patients. The HCFA evaluates each complaint. If HCFA believes that the hospital would have a CoP out of compliance, the Agency authorizes the State to conduct a substantial allegation survey.

In 1998, 1,442 allegation surveys of JCAHO-accredited hospitals were conducted with 39 found out of compliance with one or more CoPs. Also, 244 allegation surveys of non-

accredited hospitals were conducted with 12 found out of compliance with one or more CoPs. Table 5 summarizes the most frequently cited CoPs.

Table 5. Most Frequently Cited Conditions of Participation, During Allegation Surveys, 1998

Accredited Hospitals		Nonaccredited Hospitals	
Condition Not Met	Frequency	Condition Not Met	Frequency
Nursing Services	19	Governing Body	5
Quality Assurance	13	Nursing Services Quality Assurance	3 3
Governing Body	8	Emergency Services Physical Environment Infection Control	2 2 2

Rate of Disparity

As set forth in regulation at 42 CFR 488.8(d)(2)(l), following the end of a validation review period, HCFA will identify any accreditation program for which validation survey results indicate a 20 percent or more rate of disparity between the findings of the accreditation organization and the State agency. Accreditation programs with a disparity rate of 20 percent or more will be subject to a deeming authority review to determine if that organization has indeed adopted and maintained requirements comparable to HCFA's. Of the 161 JCAHO validation surveys performed in 1998, 36 showed condition-level noncompliance. Comparing the survey reports of these hospitals with the corresponding JCAHO accreditation reports, 28 of the 36 validation surveys showed comparable condition-level deficiencies.

Of the 28 validation surveys that showed comparable condition-level deficiencies, 27 were physical environment condition-level deficiencies. Each hospital identified by a State survey agency during the validation survey with a physical environment condition-level deficiency has a Plan for Improvement approved by the JCAHO. Therefore, these 27 physical environment condition-level deficiencies are not counted against the JCAHO in calculating the disparity rate. The disparity rate for 1998 is based on the 8 condition-level deficiencies identified by the State survey agencies where comparable condition-level deficiencies do not exist in the JCAHO accreditation survey reports. This equals a disparity rate of 5 percent (which is below HCFA's cutoff point of 20 percent).

Changing the Evaluation Methodology and Future Plans for Validation

The Office of the Inspector General released four reports entitled "The External Review of Hospital Quality" in July 1999. The reports were based on the OIG's broad inquiry on the external quality oversight of hospitals. The reports identified recommendations that HCFA is considering to improve its oversight role of accreditation organizations for hospitals.

HCFA has established several workgroups to develop its Hospital Quality Oversight Initative, which is designed to address the recommendations made by the OIG. HCFA has identified four goals to address the OIG recommendations. The goals to address the OIG's recommendations are: 1) Balance quality improvement and regulatory approach; 2) Improve oversight of JCAHO's activities; 3) Improve oversight of State Agency activities; and, 4) Improve oversight of nonaccredited hospitals.

Under this initiative, HCFA is considering how to revise the current validation program and oversight processes to strengthen its oversight role. HCFA expects to have a revised hospital validation program in place by Fall 2000.

Validation Surveys of Accredited Laboratories Under the Clinical Laboratory Improvement Amendments of 1988--Fiscal Year 1998 Report

Introduction

This report covers the evaluation of the performance during fiscal year 1998 of the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six approved organizations are the:

- American Association of Blood Banks (AABB)
- American Osteopathic Association (AOA)
- American Society of Histocompatibility and Immunogenetics (ASHI)
- COLA *
- College of American Pathologists (the College)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

We appreciate the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by statute, we see this as an opportunity to present information about, and dialogue with, each organization in our mutual interest in improving the quality of testing performed by clinical laboratories across the nation.

Legislative Authority and Mandate

Section 353 of the Public Health Service Act, as amended by the Clinical Laboratory Improvement Amendments of 1988 (CLIA), requires any laboratory that performs testing on human specimens to meet the requirements established by the Department of Health and Human Services (HHS) and have in effect an applicable certificate. Section 353 further provides that a laboratory meeting the standards of an approved accreditation organization may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct federal oversight by HCFA. Instead, the laboratory receives an inspection by the accreditation organization in the course of maintaining its accreditation, and by virtue of this accreditation, is "deemed" to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing and others to assure accurate and reliable laboratory examinations and procedures.

In Section 353(e)(2)(D), the Secretary is required to evaluate each approved accreditation organization by inspecting a sample of the laboratories they accredit and "such other means as the Secretary determines appropriate." In addition, Section 353(e)(3), requires the Secretary to submit

* formerly the Commission on Office Laboratory Accreditation

to Congress an annual report on the results of the evaluation. This report is submitted to satisfy that requirement. Regulations implementing Section 353 are contained in 42CFR Part 493 Laboratory Requirements. Subpart E contains the requirements for validation inspections conducted by HCFA or its agent, to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 60 days after the accreditation organization's inspection, on a representative sample basis or in response to a complaint. The results of these validation inspections or "surveys" provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization's standards and accreditation process; and

- in the aggregate, an indication of the organization's capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, at 42CFR Part 493, Subpart E, Section 493.575, provide that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization's results and the findings of the CLIA validation surveys, HCFA can re-evaluate whether the accreditation organization continues to meet the criteria for being granted deeming authority. Section 493.575 further provides that HCFA has the discretion to conduct a review of an accreditation organization program if validation review findings, irrespective of the rate of disparity, indicate such widespread or systematic problems in the organization's accreditation process that the requirements are no longer equivalent to CLIA requirements.

Validation Reviews

The validation review methodology focuses on the actual implementation of the organization's accreditation program described in its request for deeming authority. The accreditation organization's standards, as a whole, were approved by HCFA as being equivalent to, or more stringent than, the CLIA condition-level requirements, as a whole. This equivalency is the basis for granting deeming authority.

In evaluating the organization's performance, it is important to examine whether the organization's inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization's inspection process sufficiently identifies, brings about correction, and monitors for sustained correction, laboratory practices and outcomes that do not meet their accreditation standards, so that equivalency of the accreditation program is maintained.

For each laboratory in the sample, any findings from the CLIA validation survey that result in deficiencies at the condition-level** are compared to the accreditation organization's inspection results to determine comparability. If it is reasonable to conclude that one or more of those deficiencies were present in the laboratory's operations at the time of the organization's inspection, yet the inspection results did not note them, the case is a disparity. When all the cases in the sample have been reviewed, the "rate of disparity" for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys. The calculation for the disparity rate is described in Section 493.2 of the CLIA regulations.

Number of Validation Surveys Performed

The number of validation surveys is sufficient to "allow a reasonable estimate of the performance" of each accreditation organization, as indicated in the CLIA statute.

A representative sample of the more than 14,000 accredited laboratories received a validation survey in FY 98. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by any one organization fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a CLIA Certificate of Accreditation, however, was counted only once for purposes of the validation review process.

Fewer than 500 laboratories used AABB, AOA, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys were performed in AABB, AOA and ASHI-accredited laboratories. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by the other three organizations--COLA, the College or the Joint Commission. The number of validation surveys performed for the latter three organizations was roughly proportionate to each organization's representation in the total accredited laboratory universe.

Results of the Validation Reviews of Each Accreditation Organization
The findings for each organization are summarized below:

American Association of Blood Banks
Rate of disparity: No disparity

Approximately 180 laboratories used their AABB accreditation for CLIA purposes. Three validation surveys were conducted. No condition-level deficiencies were cited on any of the cases.

** A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed, more specific. A condition-level deficiency is an inadequacy in the laboratory's quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.

American Osteopathic Association
Rate of disparity: No disparity

For CLIA purposes, approximately 50 laboratories used their AOA accreditation. Four validation surveys were conducted, and no condition-level deficiencies were cited.

American Society of Histocompatibility and Immunogenetics
Rate of disparity: No disparity
About 100 laboratories used their ASHI accreditation for CLIA purposes. Two validation surveys were considered reasonable to evaluate this organization's performance. No condition-level deficiencies were cited on either validation survey.

COLA
Rate of disparity: 5%

Validation surveys were conducted at 110 COLA-accredited laboratories. Nine laboratories were cited with condition-level deficiencies. COLA inspections did not cite comparable deficiencies in five of those nine cases.

Following is a listing of the laboratory identification number and location of laboratories that had disparate inspection results by COLA, along with the CLIA condition-level requirements cited on the validation surveys.

CLIA number	Location	CLIA Conditions
04D0466496	Arkansas	Laboratory Director
		Technical Consultant
		Quality Assurance
23D0709664	Michigan	Quality Control--Routine Chemistry
		Quality Control--Endocrinology
24D0861424	Minnesota	Proficiency Testing--Enrollment
36D0338928	Ohio	Laboratory Director
		Technical Consultant
		Quality Assurance
45D0935763	Texas	Proficiency Testing--Enrollment
		General Quality Control
		Laboratory Director
		Quality Assurance

College of American Pathologists
Rate of disparity: 3%

A total of 78 validation surveys were conducted at laboratories accredited by the College. Three of the laboratories were cited with condition-level deficiencies. Comparable deficiencies were not cited

by the College for two of those laboratories.

Following is a listing of the CLIA identification number and the location of the laboratories that had disparate inspection results by the College, along with the condition-level requirements cited on the validation surveys..

CLIA number	Location	CLIA Conditions
03D0528350	Arizona	Quality Control--Immunohematology
23D0709666	Michigan	Proficiency Testing--Enrollment

Joint Commission on Accreditation of Healthcare Organizations
Rate of disparity: 3%

During this validation period, 58 validation surveys were conducted at laboratories accredited by the Joint Commission. Only two of the laboratories were cited with condition-level deficiencies, however, comparable deficiencies were not cited by the Joint Commission for either laboratory.

Following is a listing of the CLIA identification number and location of the laboratories that had disparate inspection results by the Joint Commission, along with the CLIA condition-level requirements cited on the validation surveys.

CLIA number	Location	CLIA Conditions
17D0452375	Kansas	Proficiency Testing Enrollment and Testing
21D0210256	Maryland	Quality Assurance

Conclusion

The findings of the validation review for 1998 indicate that all of the accreditation organizations approved under CLIA performed at a level well below the 20 percent threshold that would trigger a deeming authority review. The rates of disparity for all of the accreditation organizations ranged from no disparity to 5 percent. Overall, these disparity rates are the lowest of any of the years that the CLIA validation program has been in effect. Moreover, the validation review did not reveal widespread or systematic problems in accreditation process that cause the equivalency of any organization's accreditation program to be questioned.

HCFA has performed this validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. In addition to the dialogue associated with the CLIA validation program, HCFA has been active in promoting opportunities for partnering with the accreditation organizations in furthering our mutual interest in improving laboratory performance across the nation.

Report on Peer Review Organizations (PRO)

Over the last several years, HCFA has re-engineered the PRO program to better meet the Agency's strategic goal of improving the health status of Medicare beneficiaries. PROs still perform quality assurance activities in accordance with their original mandate. However, the principal focus of the PRO program has shifted from a balance between utilization review, DRG validation and quality of care review (including beneficiary complaints) to strong emphasis on quality improvement projects through the Health Care Quality Improvement Program (HCQIP). For the 6th round of PRO contracts, commencing this year, a substantial level of effort is also being directed at reducing payment errors via the Payment Error Prevention Program (PEPP).

The HCQIP relies on provider-based quality improvement, a data driven external monitoring system based on quality indicators, and sharing of comparative data and best practices with providers to stimulate improvement. PROs conduct "national" quality improvement projects that focus on important clinical topics that have the potential to improve care provided to many Medicare beneficiaries. These topics include heart attacks, breast cancer, diabetes, heart failure, pneumonia and stroke. PROs also design and structure "local" projects whereby they work collaboratively with specific providers and managed care plans in their areas, particularly with respect to disadvantaged and/or under-served beneficiary groups. PROs have also begun doing pilot projects in alternative provider settings.

Consistent with the Agency's strategic goal to promote the fiscal integrity of HCFA programs, the newly implemented PEPP activities are part of the Comprehensive Plan for Program Integrity to ensure Medicare hospital inpatient claims are billed and paid appropriately. Using HCFA-developed baseline data, each PRO is now required to conduct an analysis to identify the extent of payment errors occurring in its area; implement appropriate educational interventions aimed at changing provider behavior; and, decrease the observed payment error rate. The overall target for the 3-year contract period is a 50 percent reduction nationally in payment errors for claims by acute care hospitals operating under Medicare's Prospective Payment System.

Under Federal budget rules, the PRO program is defined as "mandatory" rather than "discretionary" because, like Medicare benefits, PRO costs are financed directly from the Trust Funds and are not subject to the annual appropriations process. PRO Trust Fund outlays in Fiscal Year (FY) 1999 totaled $213.4 million, which compares with $221.6 million spent in FY 1998.

In FY 1999, HCFA administered 53 PRO contracts, one per State, the District of Columbia, the Virgin Islands, and Puerto Rico. In the interest of improving program effectiveness, the 6th round of PRO contracts is performance-based. Each contractor is now evaluated and reimbursed through a cost plus award fee contract. PRO program efficiency was enhanced by the full implementation of the Standard Data Processing System (SDPS).

U.S. Department of Health and Human Services

Health Care Financing Administration

Glossary

HCFA

GLOSSARY

Accrual Accounting : An accounting technique that recognizes costs when incurred and revenues when earned and includes the effect of accounts receivable and accounts payable when determining annual income.

Actuarial Soundness: A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

Administrative Costs: General term that refers to Medicare and Medicaid administrative costs, as well as HCFA administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-HCFA administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. HCFA administrative costs are the costs of operating HCFA (e.g. salaries and expenses, facilities, equipment, rent and utilities, etc). These costs are reflected in the Program Management account.

Balanced Budget Act of 1997 (BBA): Major provisions include the Children's Health Insurance Program, Medicare+Choice, and expansion of preventive benefits.

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an "enrollee").

Benefit Payments: Funds outlayed or expenses accrued for services delivered to beneficiaries.

Carrier: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay physician and supplier claims.

Cash Accounting: An accounting technique that tracks outlays or expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

Cost-Based Health Maintenance Organization (HMO/Competitive Medical Plan, CMP): A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and

co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

Demonstrations: Projects and contracts that HCFA has signed with various health care organizations. These contracts allow HCFA to test various or specific attributes such as payment methodologies, preventive care, social care, etc., and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Durable Medical Equipment Regional Carrier (DMERC): A company that contracts to pay Medicare claims for purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Expenditure: Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States. This term is used interchangeably with Outlays.

Expense: An outlay or an accrued liability for services incurred in the current period. This term is used to show accrual accounting.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

Federal Insurance Contribution Act (FICA) Payroll Tax: Medicare's share of FICA is used to fund the HI Trust Fund. In FY 1999, employers and employees each contributed 1.45 percent of taxable wages, with no limitations, to the HI Trust Fund.

Federal Medical Assistance Percentage (FMAP): The portion of the Medicaid program which is paid by the Federal government.

Federal Managers' Financial Integrity Act (FMFIA): A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

Health Care Prepayment Plan (HCPP): A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Major provisions include portability provisions for group and individual health insurance, establishes the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

Hospital Insurance (HI): The part of Medicare that pays hospital and other institutional provider benefit claims. See "Part A."

Information Technology (IT): The term commonly applied to maintenance of data through computer systems.

Intermediary: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay hospital and other institutional provider benefit claims.

Internal Controls: Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment. Also known as Management controls.

Mandatory Spending: Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

Material Weakness: A serious flaw in management or internal controls requiring high-priority corrective action.

Medicare Current Beneficiary Survey (MCBS) : A comprehensive source of information on the health, health care, and socioeconomic and demographic characteristics of aged, disabled, and institutional Medicare beneficiaries.

Medicare Contractor: A collective term for carriers and intermediaries.

Medicare+Choice: A provision in the BBA that restructures HCFA's authority to contract with a variety of managed care entities, including health maintenance organizations (HMO) and Competitive Medical Plans (CMP), both of which were previously allowed to participate in Medicare, as well as preferred provider organizations

(PPO) and preferred supplier organizations (PSO), religious fraternal benefit society plans, private fee-for-service-plans, and medical saving accounts (MSAs), for which the BBA authorizes a special demonstration for up to 390,000 beneficiaries.

Medicare Integrity Program (MIP): A provision in HIPAA that sets up a revolving fund to support HCFA's program integrity program.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

Medical Review/Utilization Review (MR/UR): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

Medicare Secondary Payer (MSP): A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Obligation: Budgeted funds committed to be spent.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits. Used for cash accounting.

Part A: The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Medicare Hospital Insurance or "HI."

Part B: The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or "SMI."

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

Peer Review Organization (PRO): PROs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

Program Management: HCFA's operational account. Program Management supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other Agency responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

Provider: A health care professional or organization providing medical services.

Recipient: An individual covered by the Medicaid program, however, now referred to as a beneficiary.

Risk-Based Health Maintenance Organization (HMO)/ Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should the Medicare enrollee/ member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

Self Employment Contribution Act (SECA) Payroll Tax: Medicare's share of SECA is used to fund the HI Trust Fund. In FY 1999, self-employed individuals contributed 2.9 percent of taxable annual income, with no limitation.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

State Children's Health Insurance Program (SCHIP) (also known as Title XXI): This is a provision of the BBA that provides federal funding through HCFA to States so that they can expand child health assistance to uninsured, low-income children.

Supplementary Medical Insurance (SMI): The part of Medicare that pays physician and supplier claims. See "Part B."

Tax and Donations: State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

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